REFERENCE TITLE: uninsurable individuals; health insurance plan

State of Arizona
House of Representatives
Forty-seventh Legislature
Second Regular Session
2006

HB 2658

Introduced by
Representative Knaperek

AN ACT

AMENDING SECTIONS 20-224, 20-826.02, 20-843, 20-1057, 20-1057.09, 20-1068, 20-1073, 20-1342.04, 20-1377, 20-1378, 20-1380, 20-1408, 20-1412, 20-2308, 20-2310, 20-2331 AND 36-2982, ARIZONA REVISED STATUTES; PROVIDING FOR THE DELAYED REPEAL OF SECTIONS 20-1379, 20-1381 AND 20-1382, ARIZONA REVISED STATUTES; AMENDING TITLE 20, ARIZONA REVISED STATUTES, BY ADDING CHAPTER 22; MAKING AN APPROPRIATION; RELATING TO STATE HEALTH INSURANCE PLAN FOR UNINSURABLE INDIVIDUALS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 20-224, Arizona Revised Statutes, is amended to read:

20-224. Premium tax

A. On or before March 1 of each year each authorized domestic insurer, each other insurer and each formerly authorized insurer referred to in section 20-206, subsection B~~,~~ shall file with the director a report in a form prescribed by the director showing total direct premium income including policy membership and other fees and all other considerations for insurance from all classes of business whether designated as a premium or otherwise received by it during the preceding calendar year on account of policies and contracts covering property, subjects or risks located, resident or to be performed in this state, after deducting from such total direct premium income applicable cancellations, returned premiums, the amount of reduction in or refund of premiums allowed to industrial life policyholders for payment of premiums direct to an office of the insurer and all policy dividends, refunds, savings coupons and other similar returns paid or credited to policyholders within this state and not reapplied as premiums for new, additional or extended insurance. No deduction shall be made of the cash surrender values of policies or contracts. Considerations received on annuity contracts, as well as the unabsorbed portion of any premium deposit, shall not be included in total direct premium income, and neither shall be subject to tax. The report shall separately indicate the total direct premium income received from fire insurance premiums on property located in an incorporated city or town that procures the services of a private fire company.

B. Coincident with the filing of such tax report each insurer shall pay to the director for deposit, pursuant to sections 35-146 and 35-147, a tax of 2.0 per cent of such net premiums, except that the tax on fire insurance premiums on property located in an incorporated city or town which procures the services of a private fire company is .66 per cent, the tax on all other fire insurance premiums is 2.2 per cent and the tax on health care service and disability insurance premiums is as prescribed under sections 20-837, 20-1010 and 20-1060. Any payments of tax pursuant to subsection E of this section shall be deducted from the tax payable pursuant to this subsection. Each insurer shall reflect the cost savings attributable to the lower tax in fire insurance premiums charged on property located in an incorporated city or town that procures the services of a private fire company.

C. Eighty-five per cent of the tax paid hereunder by an insurer on account of premiums received for fire insurance shall be separately specified in the report and shall be apportioned in the manner provided by sections 9-951, 9-952 and 9-972, except that all of the tax so allocated to a fund of a municipality which has no volunteer ~~fire fighters~~ FIREFIGHTERS or pension obligations to volunteer ~~fire fighters~~ FIREFIGHTERS shall be appropriated to

the account of the municipality in the public safety personnel retirement system and all of the tax so allocated to a fund of a municipality which has both full-time paid ~~fire fighters~~ FIREFIGHTERS and volunteer ~~fire fighters~~ FIREFIGHTERS or pension obligations to full-time paid ~~fire fighters~~ FIREFIGHTERS or volunteer ~~fire fighters~~ FIREFIGHTERS shall be appropriated to the account of the municipality in the public safety personnel retirement system where it shall be reallocated by actuarial procedures proportionately to the municipality for the account of the full-time paid ~~fire fighters~~ FIREFIGHTERS and to the municipality for the account of the volunteer ~~fire fighters~~ FIREFIGHTERS. A full accounting of such reallocation shall be forwarded to the municipality and both local boards.

D. This section shall not apply to title insurance, and such insurers shall be taxed as provided in section 20-1566.

E. Any insurer which paid or is required to pay a tax of two thousand dollars or more on net premiums received during the preceding calendar year, pursuant to subsection B of this section and sections 20-224.01, 20-837, 20-1010, 20-1060 and 20-1097.07, shall file on or before the fifteenth day of each month from March through August a report for that month, on a form prescribed by the director, accompanied by a payment in an amount equal to fifteen per cent of the amount paid or required to be paid during the preceding calendar year pursuant to subsection B of this section and sections 20-224.01, 20-837, 20-1010, 20-1060 and 20-1097.07. The payments are due and payable on or before the fifteenth day of each month and shall be made to the director for deposit, pursuant to sections 35-146 and 35-147.

F. BEGINNING FROM AND AFTER DECEMBER 31, 2006, FOUR PER CENT OF THE TAX PAID UNDER THIS SECTION BY AN INSURER ON ACCOUNT OF PREMIUMS RECEIVED FOR INSURANCE SHALL BE SEPARATELY SPECIFIED IN THE REPORT AND THE DIRECTOR SHALL DEPOSIT THE AMOUNT IN THE STATE HEALTH INSURANCE PLAN FOR UNINSURABLE INDIVIDUALS FUND PURSUANT TO SECTION 20-3219. THE AMOUNT COLLECTED IN ANY CALENDAR YEAR SHALL NOT EXCEED SIXTEEN MILLION DOLLARS AND THE DIRECTOR SHALL RETURN ANY AMOUNT COLLECTED IN EXCESS OF SIXTEEN MILLION TO EACH INSURER PROPORTIONATELY.

~~F.~~ G. Except for the tax paid on fire insurance premiums pursuant to subsections B and C of this section, an insurer may claim a premium tax credit if the insurer qualifies for a credit pursuant to section 20-224.03 or 20-224.04.

Sec. 2. Section 20-826.02, Arizona Revised Statutes, is amended to read:

20-826.02. Subscription contracts; varying copayments and deductibles allowed

A. Except as provided in ~~sections 20-1379 and~~ SECTION 20-2304, a corporation may offer one or more subscription contracts that contain a choice of deductibles, coinsurance, copayments~~,~~ AND out-of-pocket and any other cost sharing levels. Plans offered under this section shall clearly disclose in marketing materials, certificates of coverage and contracts the

insured's financial responsibilities. A corporation that offers such a subscription contract shall continue to provide any mandated health coverage that is required by this state or by federal law.

B. This section does not prohibit a health benefits plan that is intended to qualify as a high deductible health plan as defined by 26 United States Code section 223 (c)(2) from requiring the application of deductibles, copayments or coinsurance to benefits provided under the health benefits plan.

Sec. 3. Section 20-843, Arizona Revised Statutes, is amended to read:

20-843. Eligibility; prohibiting cancellation because of eligibility for certain benefits

A. Except as specifically provided in ~~sections 20-1379 and~~ SECTION 20-1380, with respect to the determination of whether a person is an eligible individual, a hospital and medical service corporation shall not consider the availability of or a person's eligibility for medical assistance pursuant to title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396a (1980)) when considering eligibility for coverage or calculating payments under a plan for eligible subscribers.

B. To the extent that payment for covered expenses has been made under the state program pursuant to title XIX of the social security act for health care items or services that are furnished to an individual, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services. On presentation of proof that the state program pursuant to title XIX of the social security act has paid for covered items or services, the hospital and medical service corporation shall pay the state program pursuant to title XIX of the social security act according to the coverage provided in the contract.

C. A hospital and medical service corporation may not impose on a state agency that has been assigned the rights of an individual who is eligible for medical assistance and who is covered for health benefits from the insurer any requirements that are different from the requirements applicable to an agent or assignee of any other covered individual.

D. A hospital or medical service corporation shall not cancel or fail to renew the contract of any person based on that person's eligibility for or enrollment in a program funded under title XIX of the social security act or title 36, chapter 29 or 34. Nothing in this section prohibits cancellation or failure to renew for nonpayment of monies due under the contract.

Sec. 4. Section 20-1057, Arizona Revised Statutes, is amended to read:

20-1057. Evidence of coverage by health care services organizations; renewability; definitions

A. Every enrollee in a health care plan shall be issued an evidence of coverage by the responsible health care services organization.

B. Any contract, except accidental death and dismemberment, applied for that provides family coverage shall ALSO PROVIDE, as to such coverage of family members, ~~also provide~~ that the benefits applicable for children shall

be payable with respect to a newly born child of the enrollee from the instant of such child's birth, to a child adopted by the enrollee, regardless of the age at which the child was adopted, and to a child who has been placed for adoption with the enrollee and for whom the application and approval procedures for adoption pursuant to section 8-105 or 8-108 have been completed to the same extent that such coverage applies to other members of the family. The coverage for newly born or adopted children or children placed for adoption shall include coverage of injury or sickness including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for a child, the contract may require that notification of birth, adoption or adoption placement of the child and payment of the required premium must be furnished to the insurer within thirty-one days after the date of birth, adoption or adoption placement in order to have the coverage continue beyond the thirty-one day period.

C. Any contract, except accidental death and dismemberment, that provides coverage for psychiatric, drug abuse or alcoholism services shall require the health care services organization to provide reimbursement for such services in accordance with the terms of the contract without regard to whether the covered services are rendered in a psychiatric special hospital or general hospital.

D. No evidence of coverage or amendment to the coverage shall be issued or delivered to any person in this state until a copy of the form of the evidence of coverage or amendment to the coverage has been filed with and approved by the director.

E. An evidence of coverage shall contain a clear and complete statement if a contract, or a reasonably complete summary if a certificate of contract, of:

1. The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health care plan.

2. Any limitations of the services, kind of services, benefits or kind of benefits to be provided, including any deductible or copayment feature.

3. Where and in what manner information is available as to how services may be obtained.

4. The enrollee's obligation, if any, respecting charges for the health care plan.

F. An evidence of coverage shall not contain provisions or statements that are unjust, unfair, inequitable, misleading or deceptive, that encourage misrepresentation or that are untrue.

G. The director shall approve any form of evidence of coverage if the requirements of subsections E and F of this section are met. It is unlawful to issue such form until approved. If the director does not disapprove any such form within forty-five days after the filing of the form, it is deemed approved. If the director disapproves a form of evidence of coverage, the director shall notify the health care services organization. In the notice,

the director shall specify the reasons for the director's disapproval. The director shall grant a hearing on such disapproval within fifteen days after a request for a hearing in writing is received from the health care services organization.

H. A health care services organization shall not cancel or refuse to renew an enrollee's evidence of coverage that was issued on a group basis without giving notice of the cancellation or nonrenewal to the enrollee and, on request of the director, to the department of insurance. A notice by the organization to the enrollee of cancellation or nonrenewal of the enrollee's evidence of coverage shall be mailed to the enrollee at least sixty days before the effective date of such cancellation or nonrenewal. The notice shall include or be accompanied by a statement in writing of the reasons as stated in the contract for such action by the organization. Failure of the organization to comply with this subsection shall invalidate any cancellation or nonrenewal except a cancellation or nonrenewal for nonpayment of premium, for fraud or misrepresentation in the application or other enrollment documents or for loss of eligibility as defined in the evidence of coverage. A health care services organization shall not cancel an enrollee's evidence of coverage issued on a group basis because of the enrollee's or dependent's age, except for loss of eligibility as defined in the evidence of coverage, sex, health status-related factor, national origin or frequency of utilization of health care services of the enrollee. An evidence of coverage issued on a group basis shall clearly delineate all terms under which the health care services organization may cancel or refuse to renew an evidence of coverage for an enrollee or dependent. Nothing in this subsection prohibits the cancellation or nonrenewal of a health benefits plan contract issued on a group basis for any of the reasons allowed in section 20-2309. A health care services organization may cancel or nonrenew an evidence of coverage issued to an individual on a nongroup basis only for the reasons allowed by subsection N of this section.

I. A health care plan that provides coverage for surgical services for a mastectomy shall also provide coverage incidental to the patient's covered mastectomy for surgical services for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, treatment of physical complications for all stages of the mastectomy, including lymphedemas, and at least two external postoperative prostheses subject to all of the terms and conditions of the policy.

J. A contract that provides coverage for surgical services for a mastectomy shall also provide coverage for mammography screening performed on dedicated equipment for diagnostic purposes on referral by a patient's physician, subject to all of the terms and conditions of the policy and according to the following guidelines:

1. A baseline mammogram for a woman from age thirty-five to thirty-nine.

2. A mammogram for a woman from age forty to forty-nine every two years or more frequently based on the recommendation of the woman's physician.

3. A mammogram every year for a woman fifty years of age and over.

K. Any contract that is issued to the enrollee and that provides coverage for maternity benefits shall also provide that the maternity benefits apply to the costs of the birth of any child legally adopted by the enrollee if all the following are true:

1. The child is adopted within one year of birth.

2. The enrollee is legally obligated to pay the costs of birth.

3. All preexisting conditions and other limitations have been met and all deductibles and copayments have been paid by the enrollee.

4. The enrollee has notified the insurer of the enrollee's acceptability to adopt children pursuant to section 8-105 within sixty days after such approval or within sixty days after a change in insurance policies, plans or companies.

L. The coverage prescribed by subsection K of this section is excess to any other coverage the natural mother may have for maternity benefits except coverage made available to persons pursuant to title 36, chapter 29 but not including coverage made available to persons defined as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If such other coverage exists the agency, attorney or individual arranging the adoption shall make arrangements for the insurance to pay those costs that may be covered under that policy and shall advise the adopting parent in writing of the existence and extent of the coverage without disclosing any confidential information such as the identity of the natural parent. The enrollee adopting parents shall notify their health care services organization of the existence and extent of the other coverage. A health care services organization is not required to pay any costs in excess of the amounts it would have been obligated to pay to its hospitals and providers if the natural mother and child had received the maternity and newborn care directly from or through that health care services organization.

M. Each health care services organization shall offer membership to the following in a conversion plan that provides the basic health care benefits required by the director:

1. Each enrollee including the enrollee's enrolled dependents leaving a group.

2. Each enrollee and the enrollee's dependents who would otherwise cease to be eligible for membership because of the age of the enrollee or the enrollee's dependents or the death or the dissolution of marriage of an enrollee.

N. A health care services organization shall not cancel or nonrenew an evidence of coverage issued to an individual on a nongroup basis, including a conversion plan, except for any of the following reasons and in compliance

with the notice and disclosure requirements contained in subsection H of this section:

1. The individual has failed to pay premiums or contributions in accordance with the terms of the evidence of coverage or the health care services organization has not received premium payments in a timely manner.

2. The individual has performed an act or practice that constitutes fraud or the individual made an intentional misrepresentation of material fact under the terms of the evidence of coverage.

3. The health care services organization has ceased to offer coverage to individuals that is consistent with the requirements of ~~sections 20-1379 and~~ SECTION 20-1380.

4. If the health care services organization offers a health care plan in this state through a network plan, the individual no longer resides, lives or works in the service area served by the network plan or in an area for which the health care services organization is authorized to transact business but only if the coverage is terminated uniformly without regard to any health status-related factor of the covered individual.

5. If the health care services organization offers health coverage in this state in the individual market only through one or more bona fide associations, the membership of the individual in the association has ceased but only if that coverage is terminated uniformly without regard to any health status-related factor of any covered individual.

O. A conversion plan may be modified if the modification complies with the notice and disclosure provisions for cancellation and nonrenewal under subsection H of this section. A modification of a conversion plan that has already been issued shall not result in the effective elimination of any benefit originally included in the conversion plan.

P. Any person who is a United States armed forces reservist, who is ordered to active military duty on or after August 22, 1990 and who was enrolled in a health care plan shall have the right to reinstate such coverage upon release from active military duty subject to the following conditions:

1. The reservist shall make written application to the health plan within ninety days of discharge from active military duty or within one year of hospitalization continuing after discharge. Coverage shall be effective upon receipt of the application by the health plan.

2. The health plan may exclude from such coverage any health or physical condition arising during and occurring as a direct result of active military duty.

Q. The director shall adopt emergency rules applicable to persons who are leaving active service in the armed forces of the United States and returning to civilian status consistent with ~~the provisions of~~ subsection P of this section including:

1. Conditions of eligibility.

2. Coverage of dependents.

3. Preexisting conditions.
4. Termination of insurance.
5. Probationary periods.
6. Limitations.
7. Exceptions.
8. Reductions.
9. Elimination periods.
10. Requirements for replacement.
11. Any other conditions of evidences of coverage.

R. Any contract that provides maternity benefits shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight hours following a normal vaginal delivery or ninety-six hours following a cesarean section. The contract shall not require the provider to obtain authorization from the health care services organization for prescribing the minimum length of stay required by this subsection. The contract may provide that an attending provider in consultation with the mother may discharge the mother or the newborn child before the expiration of the minimum length of stay required by this subsection. The health care services organization shall not:

1. Deny the mother or the newborn child eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract solely for the purpose of avoiding the requirements of this subsection.

2. Provide monetary payments or rebates to mothers to encourage those mothers to accept less than the minimum protections available pursuant to this subsection.

3. Penalize or otherwise reduce or limit the reimbursement of an attending provider because that provider provided care to any insured under the contract in accordance with this subsection.

4. Provide monetary or other incentives to an attending provider to induce that provider to provide care to an insured under the contract in a manner that is inconsistent with this subsection.

5. Except as described in subsection S of this section, restrict benefits for any portion of a period within the minimum length of stay in a manner that is less favorable than the benefits provided for any preceding portion of that stay.

S. Nothing in subsection R of this section:

1. Requires a mother to give birth in a hospital or to stay in the hospital for a fixed period of time following the birth of the child.

2. Prevents a health care services organization from imposing deductibles, coinsurance or other cost sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn child under the contract, except that any coinsurance or other cost sharing for any portion of a period within a hospital length of stay required

pursuant to subsection R of this section shall not be greater than the coinsurance or cost sharing for any preceding portion of that stay.

3. Prevents a health care services organization from negotiating the level and type of reimbursement with a provider for care provided in accordance with subsection R of this section.

T. Any contract or evidence of coverage that provides coverage for diabetes shall also provide coverage for equipment and supplies that are medically necessary and that are prescribed by a health care provider including:

1. Blood glucose monitors.

2. Blood glucose monitors for the legally blind.

3. Test strips for glucose monitors and visual reading and urine testing strips.

4. Insulin preparations and glucagon.

5. Insulin cartridges.

6. Drawing up devices and monitors for the visually impaired.

7. Injection aids.

8. Insulin cartridges for the legally blind.

9. Syringes and lancets including automatic lancing devices.

10. Prescribed oral agents for controlling blood sugar that are included on the plan formulary.

11. To the extent coverage is required under medicare, podiatric appliances for prevention of complications associated with diabetes.

12. Any other device, medication, equipment or supply for which coverage is required under medicare from and after January 1, 1999. The coverage required in this paragraph is effective six months after the coverage is required under medicare.

U. Nothing in subsection T of this section:

1. Entitles a member or enrollee of a health care services organization to equipment or supplies for the treatment of diabetes that are not medically necessary as determined by the health care services organization medical director or the medical director's designee.

2. Provides coverage for diabetic supplies obtained by a member or enrollee of a health care services organization without a prescription unless otherwise permitted pursuant to the terms of the health care plan.

3. Prohibits a health care services organization from imposing deductibles, coinsurance or other cost sharing in relation to benefits for equipment or supplies for the treatment of diabetes.

V. Any contract or evidence of coverage that provides coverage for prescription drugs shall not limit or exclude coverage for any prescription drug prescribed for the treatment of cancer on the basis that the prescription drug has not been approved by the United States food and drug administration for the treatment of the specific type of cancer for which the prescription drug has been prescribed, if the prescription drug has been recognized as safe and effective for treatment of that specific type of

cancer in one or more of the standard medical reference compendia prescribed in subsection W of this section or medical literature that meets the criteria prescribed in subsection W of this section. The coverage required under this subsection includes covered medically necessary services associated with the administration of the prescription drug. This subsection does not:

1. Require coverage of any prescription drug used in the treatment of a type of cancer if the United States food and drug administration has determined that the prescription drug is contraindicated for that type of cancer.

2. Require coverage for any experimental prescription drug that is not approved for any indication by the United States food and drug administration.

3. Alter any law with regard to provisions that limit the coverage of prescription drugs that have not been approved by the United States food and drug administration.

4. Notwithstanding section 20-1057.02, require reimbursement or coverage for any prescription drug that is not included in the drug formulary or list of covered prescription drugs specified in the contract or evidence of coverage.

5. Notwithstanding section 20-1057.02, prohibit a contract or evidence of coverage from limiting or excluding coverage of a prescription drug, if the decision to limit or exclude coverage of the prescription drug is not based primarily on the coverage of prescription drugs required by this section.

6. Prohibit the use of deductibles, coinsurance, copayments or other cost sharing in relation to drug benefits and related medical benefits offered.

W. For the purposes of subsection V of this section:

1. The acceptable standard medical reference compendia are the following:

(a) The American medical association drug evaluations, a publication of the American medical association.

(b) The American hospital formulary service drug information, a publication of the American society of health system pharmacists.

(c) Drug information for the health care provider, a publication of the United States pharmacopoeia convention.

2. Medical literature may be accepted if all of the following apply:

(a) At least two articles from major peer reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.

(b) No article from a major peer reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be

determined for the treatment of the indication for which the drug has been prescribed.

(c) The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States department of health and human services as acceptable peer reviewed medical literature pursuant to section 186(t)(2)(B) of the social security act (42 United States Code section 1395x(t)(2)(B)).

X. A health care services organization shall not issue or deliver any advertising matter or sales material to any person in this state until the health care services organization files the advertising matter or sales material with the director. This subsection does not require a health care services organization to have the prior approval of the director to issue or deliver the advertising matter or sales material. If the director finds that the advertising matter or sales material, in whole or in part, is false, deceptive or misleading, the director may issue an order disapproving the advertising matter or sales material, directing the health care services organization to cease and desist from issuing, circulating, displaying or using the advertising matter or sales material within a period of time specified by the director but not less than ten days and imposing any penalties prescribed in this title. At least five days before issuing an order pursuant to this subsection, the director shall provide the health care services organization with a written notice of the basis of the order to provide the health care services organization with an opportunity to cure the alleged deficiency in the advertising matter or sales material within a single five day period for the particular advertising matter or sales material at issue. The health care services organization may appeal the director's order pursuant to title 41, chapter 6, article 10. Except as otherwise provided in this subsection, a health care services organization may obtain a stay of the effectiveness of the order as prescribed in section 20-162. If the director certifies in the order and provides a detailed explanation of the reasons in support of the certification that continued use of the advertising matter or sales material poses a threat to the health, safety or welfare of the public, the order may be entered immediately without opportunity for cure and the effectiveness of the order is not stayed pending the hearing on the notice of appeal but the hearing shall be promptly instituted and determined.

Y. Any contract or evidence of coverage that is offered by a health care services organization and that contains a prescription drug benefit shall provide coverage of medical foods to treat inherited metabolic disorders as provided by this section.

Z. The metabolic disorders triggering medical foods coverage under this section shall:

1. Be part of the newborn screening program prescribed in section 36-694.

2. Involve amino acid, carbohydrate or fat metabolism.

3. Have medically standard methods of diagnosis, treatment and monitoring including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues.

4. Require specially processed or treated medical foods that are generally available only under the supervision and direction of a physician who is licensed pursuant to title 32, chapter 13 or 17, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

AA. Medical foods eligible for coverage under this section shall be prescribed or ordered under the supervision of a physician licensed pursuant to title 32, chapter 13 or 17 as medically necessary for the therapeutic treatment of an inherited metabolic disease.

BB. A health care services organization shall cover at least fifty per cent of the cost of medical foods prescribed to treat inherited metabolic disorders and covered pursuant to this section. An organization may limit the maximum annual benefit for medical foods under this section to five thousand dollars, which applies to the cost of all prescribed modified low protein foods and metabolic formula.

CC. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization.

DD. For the purposes of:

1. This section:

(a) "Inherited metabolic disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the newborn screening program prescribed in section 36-694.

(b) "Medical foods" means modified low protein foods and metabolic formula.

(c) "Metabolic formula" means foods that are all of the following:

(i) Formulated to be consumed or administered enterally under the supervision of a physician who is licensed pursuant to title 32, chapter 13 or 17.

(ii) Processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs.

(iii) Administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation.

(iv) Essential to a person's optimal growth, health and metabolic homeostasis.

(d) "Modified low protein foods" means foods that are all of the following:

(i) Formulated to be consumed or administered enterally under the supervision of a physician who is licensed pursuant to title 32, chapter 13 or 17.

(ii) Processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein.

(iii) Administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation.

(iv) Essential to a person's optimal growth, health and metabolic homeostasis.

2. Subsection B of this section, "child", for purposes of initial coverage of an adopted child or a child placed for adoption but not for purposes of termination of coverage of such child, means a person under the age of eighteen years.

Sec. 5. Section 20-1057.09, Arizona Revised Statutes, is amended to read:

20-1057.09. Health care services organizations; varying copayments and deductibles allowed

A. Except as provided in ~~sections 20-1379 and~~ SECTION 20-2304, a health care services organization may offer one or more health care plans that contain a choice of deductibles, coinsurance, copayments~~,~~ AND out-of-pocket and any other cost sharing levels. Plans offered under this section shall clearly disclose in marketing materials, certificates of coverage and contracts the insured's financial responsibilities. A health care services organization that offers such a health care plan shall continue to provide any mandated health coverage that is required by this state or by federal law.

B. This section does not prohibit a health benefits plan that is intended to qualify as a high deductible health plan as defined by 26 United States Code section 223 (c)(2) from requiring the application of deductibles, copayments or coinsurance to benefits provided under the health benefits plan.

Sec. 6. Section 20-1068, Arizona Revised Statutes, is amended to read:

20-1068. Statutory construction and relationship to other laws

A. Except as they relate to an insurer or a hospital or medical service corporation, the provisions of this title are applicable to health care services organizations only as provided in this article, chapter 1 of this title, chapter 2, article 12 of this title, chapter 3, articles 1 and 2 of this title, sections 20-223, 20-233, 20-234, 20-261, 20-261.01, 20-261.02, 20-261.03, 20-261.04, 20-1133, 20-1135~~, 20-1379~~ and 20-1380, section 20-1408,

subsections C through K, chapter 6, article 16 of this title and chapters 11, 15, 17, 20 and 21 of this title.

B. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization.

Sec. 7. Section 20-1073, Arizona Revised Statutes, is amended to read:

20-1073. Eligibility; prohibiting cancellation because of eligibility for certain benefits

A. Except as specifically provided in ~~sections 20-1379 and 20-1380~~ SECTION 20-3207, with respect to the determination of whether a person is an eligible individual, a health care services organization shall not consider the availability of or a person's eligibility for medical assistance under a program pursuant to title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396a (1980)) when considering eligibility for coverage or calculating payments under its plan for eligible enrollees.

B. To the extent that payment for covered expenses has been made under the state program pursuant to title XIX of the social security act for health care items or services furnished to an individual, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services. On presentation of proof that the state program pursuant to title XIX of the social security act has paid for covered items or services, the health care services organization shall make payments to the state program pursuant to title XIX of the social security act according to the coverage provided in the evidence of coverage.

C. A health care services organization may not impose on a state agency that has been assigned the rights of an individual who is eligible for medical assistance and who is covered for health benefits from the insurer any requirements that are different from the requirements applicable to an agent or assignee of any other covered individual.

D. A health care services organization shall not cancel or fail to renew the contract of any person based on that person's eligibility for or enrollment in a program funded under title XIX of the social security act or title 36, chapter 29 or 34. Nothing in this section prohibits cancellation or failure to renew for nonpayment of monies due under the contract.

Sec. 8. Section 20-1342.04, Arizona Revised Statutes, is amended to read:

20-1342.04. Disability insurance policies; varying copayments and deductibles allowed

A. Except as provided in ~~sections 20-1379 and~~ SECTION 20-2304, a disability insurer may offer one or more disability insurance policies that contain a choice of deductibles, coinsurance, copayments~~,~~ AND out-of-pocket and any other cost sharing levels. Plans offered under this section shall clearly disclose in marketing materials, certificates of coverage and contracts the insured's financial responsibilities. A disability insurer

that offers such a disability insurance policy shall continue to provide any mandated health coverage that is required by this state or by federal law.

B. This section does not prohibit a health benefits plan that is intended to qualify as a high deductible health plan as defined by 26 United States Code section 223 (c)(2) from requiring the application of deductibles, copayments or coinsurance to benefits provided under the health benefits plan.

Sec. 9. Section 20-1377, Arizona Revised Statutes, is amended to read:

20-1377. Continuation of coverage under individual policies; requirements; exceptions; renewability

A. A policy of disability insurance delivered or issued for delivery in this state shall provide for the right of covered family members to continue coverage on the death of the named insured, the entry of a decree of dissolution of marriage of the named insured and any other conditions, other than failure of the insured to pay the required premium, specifically stated in the policy under which coverage would otherwise terminate as to the covered spouse or covered dependent children of the named insured.

B. At the option of the insurer, coverage shall ~~either~~ continue EITHER under the existing policy or by the issuance of a converted policy with the person exercising the right to convert designated as the named insured. Coverage provided by a conversion policy must provide benefits most similar to the coverage contained in the policy that was terminated. A person entitled to continuation or conversion rights under this section may elect a lesser form of coverage.

C. Continuation or conversion of coverage may INCLUDE, at the option of the spouse exercising the right, ~~include~~ covered dependent children for whom the spouse has responsibility for care or support.

D. The person exercising the continuation or conversion rights shall notify the insurer and make payment of the appropriate premium within thirty-one days following the termination of the existing policy. A monthly premium rate shall be offered to the person exercising continuation or conversion rights, and payment of one monthly premium shall be deemed sufficient consideration to enact the continuation or conversion policy.

E. Coverage provided through continuation or conversion shall be without additional evidence of insurability and shall not impose any preexisting condition limitations, exclusions or other contractual time limitations other than those remaining unexpired under the policy or contract from which continuation or conversion is exercised.

F. Conversion is not available to a person who is eligible for medicare or eligible for or covered by other similar disability benefits which together with the conversion coverage would constitute overinsurance.

G. This section does not apply to disability income policies, to accidental death or dismemberment policies or to single term nonrenewable policies.

H. Each policy of disability insurance shall include notice of the continuation and conversion privilege.

I. Except as provided in subsection J of this section, any policy, including a conversion or continuation policy, that is issued under this section shall not be cancelled or nonrenewed except for the following reasons:

1. The individual has failed to pay premiums or contributions in accordance with the terms of the coverage or the insurer has not received premium payments in a timely manner.

2. The individual has performed an act or practice that constitutes fraud or the individual made an intentional misrepresentation of material fact under the terms of the coverage.

3. The insurer has ceased to offer coverage to individuals that is consistent with the requirements of ~~sections 20-1379 and~~ SECTION 20-1380.

4. If the insurer offers health care coverage in this state through a network plan, the individual no longer resides, lives or works in the service area served by the network plan or in an area for which the insurer is authorized to transact business but only if the coverage is terminated uniformly without regard to any health status-related factor of any covered individual.

5. If the insurer offers health care coverage in this state in the individual market only through one or more bona fide associations, the membership of the individual in the association has ceased but only if that coverage is terminated uniformly without regard to any health status-related factor of any covered individual.

J. An insurer who offers only one form of an individual medical expense policy may modify the conversion policy if the modification complies with the notice and disclosure requirements set forth in the policy and applies uniformly to the policy offered to the general public and to the conversion policy.

K. At the time of filing a petition for dissolution of marriage, the clerk of the court shall provide to the petitioner for a dissolution of marriage two copies of the notice of the right of a dependent spouse to convert health insurance coverage under this section. The petitioner shall cause one copy of the notice to be served on the respondent together with a copy of the petition, summons and preliminary injunction. The director shall prepare the notice, which must include a summary of this section. The clerk of the court or the director is not liable for damages arising from information contained in or omitted from the notices prepared or provided under this ~~section~~ SUBSECTION.

L. Any person who is a United States armed forces reservist, who is ordered to active military duty on or after August 22, 1990 and who had coverage under an individual disability insurance policy at such time shall have the right to reinstate such coverage upon release from active military duty subject to the following conditions:

1. The reservist shall make written application to the insurer within ninety days of discharge from active military duty or within one year of hospitalization continuing after discharge. Coverage shall be effective upon receipt of application by the insurer.

2. The insurer may exclude from such coverage any health or physical condition arising during and occurring as a direct result of active military duty.

M. Each dependent of a person eligible for reinstatement under SUBSECTION L OF this section shall be afforded the same rights and be subject to the same conditions as the insured, if the dependent was insured under the individual disability insurance policy at the time the eligible person entered active duty. Any dependent of such person born during the period of active military duty shall have the same rights as other dependents noted in this ~~section~~ SUBSECTION.

N. The director shall adopt emergency rules applicable to persons who are leaving active service in the armed forces of the United States and returning to civilian status consistent with ~~the provisions of~~ subsection L of this section, including:

1. Conditions of eligibility.
2. Coverage of dependents.
3. Preexisting conditions.
4. Termination of insurance.
5. Probationary periods.
6. Limitations.
7. Exceptions.
8. Reductions.
9. Elimination periods.
10. Requirements for replacement.
11. Any other conditions of coverage.

Sec. 10. Section 20-1378, Arizona Revised Statutes, is amended to read:

20-1378. Eligibility; prohibiting cancellation because of eligibility for certain benefits

A. Except as specifically provided in ~~sections 20-1379 and 20-1380~~ SECTION 20-3207, with respect to the determination of whether a person is an eligible individual, an insurer issuing disability insurance contracts shall not consider the availability of or a person's eligibility for medical assistance pursuant to title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396a (1980)) when considering eligibility for coverage or calculating payments under its plans for eligible policyholders.

B. To the extent that payment for covered expenses has been made under the state program pursuant to title XIX of the social security act for health care items or services furnished to an individual, the state is considered to have acquired the rights of the individual to payment by any other party for

those health care items or services. On presentation of proof that the state program pursuant to title XIX of the social security act has paid for covered items or services, the insurer shall make payments to the state program pursuant to title XIX of the social security act according to the coverage provided in the disability insurance policy.

C. An insurer issuing disability insurance contracts may not impose on a state agency that has been assigned the rights of an individual who is eligible for medical assistance and who is covered for health benefits from the insurer any requirements that are different from the requirements applicable to an agent or assignee of any other covered individual.

D. An insurer issuing disability insurance contracts shall not cancel or fail to renew the contract of any person based on that person's eligibility for or enrollment in a program funded under title XIX of the social security act or title 36, chapter 29 or 34. Nothing in this section prohibits cancellation or failure to renew for nonpayment of monies due under the contract.

Sec. 11. Delayed repeal

Section 20-1379, Arizona Revised Statutes, is repealed from and after June 30, 2007.

Sec. 12. Section 20-1380, Arizona Revised Statutes, is amended to read:

20-1380. Guaranteed renewability of individual health coverage; certificate of creditable coverage; definitions

A. Except as provided in this section, on request of the insured individual, a health care insurer that provides individual health coverage to the individual shall renew or continue that coverage.

B. A health care insurer may nonrenew or discontinue the health insurance coverage of an individual in the individual market only for one or more of the following reasons:

1. The individual has failed to pay premiums or contributions pursuant to the terms of the health insurance coverage or the health care insurer has not received premium payments in a timely manner.

2. The individual has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact under the terms of the coverage.

3. The health care insurer has ceased to offer coverage in the individual market pursuant to subsection C of this section.

4. If the health care insurer offers health care coverage through a network plan in this state, the individual no longer resides, lives or works in the service area or in an area served by the network plan for which the health care insurer is authorized to do business but only if the coverage is terminated uniformly without regard to any health status-related factor of any covered individual.

5. If the health care insurer offers health coverage in the individual market only through one or more bona fide associations, the membership of an

individual in the association has ceased but only if that coverage is terminated uniformly without regard to any health status-related factor of any covered individual.

C. If a health care insurer decides to discontinue offering a particular policy form offered in the individual market, the health care insurer may discontinue that policy form only if:

1. The health care insurer provides notice to the director at least five business days before the health care insurer gives notice to each individual covered under that policy form of the intention to discontinue offering that policy form in this state.

2. The health care insurer provides notice to each individual who is covered by that policy form in the individual market at least ninety days before the date of the discontinuation of that policy form.

3. The health care insurer offers to each individual in the individual market whose coverage is discontinued pursuant to this subsection the option to purchase all other individual health insurance coverage currently offered by the health care insurer for individuals in that market.

4. In exercising the option to discontinue that type of coverage and in offering the option of coverage prescribed in paragraph 3 of this subsection, the health care insurer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for that coverage.

D. If a health care insurer elects to discontinue offering all health insurance coverage in the individual market in this state, the health care insurer may discontinue that coverage only if all of the following occur:

1. The health care insurer gives notice to the director at least five business days before the health care insurer gives notice to each individual of the intention to discontinue offering health insurance coverage in the individual market in this state.

2. The health care insurer provides notice to each individual of that discontinuation at least one hundred eighty days before the date of the expiration of that coverage.

3. The health care insurer discontinues all individual insurance or coverage that was issued or delivered for issuance in this state and does not renew any coverage that was offered or sold in this state.

E. If the health care insurer discontinues offering health insurance coverage pursuant to subsection D of this section, the health care insurer shall not issue any health insurance coverage in this state in the individual market for five years after the date that the last individual health insurance coverage was not renewed.

F. Subsection C of this section does not apply if the health care insurer modifies the health coverage at the time of renewal and that modification is otherwise consistent with this title and effective on a uniform basis among all individuals covered by that policy form.

~~G. A health care insurer shall provide the certification described in section 20-2310, subsection G if the individual:~~

~~1. Ceases to be covered under a policy offered by a health care insurer or otherwise becomes covered under a COBRA continuation provision.~~

~~2. Who was covered under a COBRA continuation provision ceases to be covered under the COBRA continuation provision.~~

~~3. Requests certification from the health care insurer within twenty-four months after the coverage under a policy offered by a health care insurer ceases.~~

~~H. The director may use independent contractor examiners pursuant to sections 20-148 and 20-159 to review the higher level of coverage and lower level of coverage policy forms offered by a health care insurer in compliance with this section and section 20-1379. All examination and examination related expenses shall be borne by the insurer and shall be paid by the insurance examiners' revolving fund pursuant to section 20-159.~~

G. A HEALTH CARE INSURER SHALL PROVIDE, WITHOUT CHARGE, A WRITTEN CERTIFICATE OF CREDITABLE COVERAGE AS DESCRIBED IN THIS SECTION FOR CREDITABLE COVERAGE OCCURRING AFTER JUNE 30, 1996 IF THE INDIVIDUAL:

1. CEASES TO BE COVERED UNDER A POLICY OFFERED BY A HEALTH CARE INSURER. AN INDIVIDUAL WHO IS COVERED BY A POLICY THAT IS ISSUED ON A GROUP BASIS BY A HEALTH CARE INSURER, THAT IS TERMINATED OR NOT RENEWED AT THE CHOICE OF THE SPONSOR OF THE GROUP AND FOR WHICH THE REPLACEMENT OF THE COVERAGE IS WITHOUT A BREAK IN COVERAGE IS NOT ENTITLED TO RECEIVE THE CERTIFICATION PRESCRIBED IN THIS PARAGRAPH BUT IS INSTEAD ENTITLED TO RECEIVE THE CERTIFICATION PRESCRIBED IN PARAGRAPH 2 OF THIS SUBSECTION.

2. REQUESTS CERTIFICATION FROM THE HEALTH CARE INSURER WITHIN TWENTY-FOUR MONTHS AFTER THE COVERAGE UNDER A HEALTH INSURANCE COVERAGE POLICY OFFERED BY A HEALTH CARE INSURER CEASES.

H. THE CERTIFICATE OF CREDITABLE COVERAGE PROVIDED BY A HEALTH CARE INSURER IS A WRITTEN CERTIFICATION OF THE PERIOD OF CREDITABLE COVERAGE OF THE INDIVIDUAL UNDER THE HEALTH INSURANCE COVERAGE OFFERED BY THE HEALTH CARE INSURER. THE DEPARTMENT MAY ENFORCE AND MONITOR THE ISSUANCE AND DELIVERY OF THE NOTICES AND CERTIFICATES BY HEALTH CARE INSURERS AS REQUIRED BY THIS SECTION, THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (P.L. 104-191; 110 STAT. 1936) AND ANY FEDERAL REGULATIONS ADOPTED TO IMPLEMENT THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996.

I. ANY HEALTH CARE INSURER, ACCOUNTABLE HEALTH PLAN OR OTHER ENTITY THAT ISSUES HEALTH CARE COVERAGE IN THIS STATE, AS APPLICABLE, OTHER THAN THE STATE HEALTH INSURANCE PLAN FOR UNINSURABLE INDIVIDUALS, SHALL ISSUE AND ACCEPT A CERTIFICATE OF CREDITABLE COVERAGE OF THE INDIVIDUAL THAT CONTAINS AT LEAST THE FOLLOWING INFORMATION:

1. THE DATE THAT THE CERTIFICATE IS ISSUED.

2. THE NAME OF THE INDIVIDUAL OR DEPENDENT FOR WHOM THE CERTIFICATE APPLIES AND ANY OTHER INFORMATION THAT IS NECESSARY TO ALLOW THE ISSUER PROVIDING THE COVERAGE SPECIFIED IN THE CERTIFICATE TO IDENTIFY THE

INDIVIDUAL, INCLUDING THE INDIVIDUAL'S IDENTIFICATION NUMBER UNDER THE POLICY AND THE NAME OF THE POLICYHOLDER IF THE CERTIFICATE IS FOR OR INCLUDES A DEPENDENT.

3. THE NAME, ADDRESS AND TELEPHONE NUMBER OF THE ISSUER PROVIDING THE CERTIFICATE.

4. THE TELEPHONE NUMBER TO CALL FOR FURTHER INFORMATION REGARDING THE CERTIFICATE.

5. ONE OF THE FOLLOWING:

(a) A STATEMENT THAT THE INDIVIDUAL HAS AT LEAST EIGHTEEN MONTHS OF CREDITABLE COVERAGE. FOR THE PURPOSES OF THIS SUBDIVISION, "EIGHTEEN MONTHS" MEANS FIVE HUNDRED FORTY-SIX DAYS.

(b) BOTH THE DATE THAT THE INDIVIDUAL FIRST SOUGHT COVERAGE, AS EVIDENCED BY A SUBSTANTIALLY COMPLETE APPLICATION, AND THE DATE THAT CREDITABLE COVERAGE BEGAN.

6. THE DATE CREDITABLE COVERAGE ENDED, UNLESS THE CERTIFICATE INDICATES THAT CREDITABLE COVERAGE IS CONTINUING FROM THE DATE OF THE CERTIFICATE.

7. THE CONSUMER ASSISTANCE TELEPHONE NUMBER FOR THE DEPARTMENT.

8. THE FOLLOWING STATEMENT IN AT LEAST FOURTEEN POINT TYPE:

IMPORTANT NOTICE!

KEEP THIS CERTIFICATE WITH YOUR IMPORTANT PERSONAL RECORDS TO PROTECT YOUR RIGHTS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA"). THIS CERTIFICATE IS PROOF OF YOUR PRIOR HEALTH INSURANCE COVERAGE. YOU MAY NEED TO SHOW THIS CERTIFICATE TO HAVE A GUARANTEED RIGHT TO BUY NEW HEALTH INSURANCE FROM THE STATE HEALTH INSURANCE PLAN FOR UNINSURABLE INDIVIDUALS ("GUARANTEED ISSUE"). THIS CERTIFICATE MAY ALSO HELP YOU AVOID WAITING PERIODS OR EXCLUSIONS FOR PREEXISTING CONDITIONS. UNDER HIPAA, THESE RIGHTS ARE GUARANTEED ONLY FOR A VERY SHORT TIME PERIOD. AFTER YOUR GROUP COVERAGE ENDS, YOU MUST APPLY FOR NEW COVERAGE WITHIN SIXTY-THREE DAYS TO BE PROTECTED BY HIPAA. IF YOU HAVE QUESTIONS, CALL THE ARIZONA DEPARTMENT OF INSURANCE.

J. A HEALTH CARE INSURER HAS SATISFIED THE CERTIFICATION REQUIREMENT UNDER THIS SECTION IF THE INSURER OFFERING THE HEALTH BENEFITS PLAN PROVIDES THE CERTIFICATE OF CREDITABLE COVERAGE PURSUANT TO THIS SECTION WITHIN THIRTY DAYS AFTER THE EVENT THAT TRIGGERED THE ISSUANCE OF THE CERTIFICATE.

K. PERIODS OF CREDITABLE COVERAGE FOR AN INDIVIDUAL ARE ESTABLISHED BY THE PRESENTATION OF THE CERTIFICATE DESCRIBED IN THIS SECTION AND SECTION 20-2310. IN ADDITION TO THE WRITTEN CERTIFICATE OF CREDITABLE COVERAGE AS DESCRIBED IN THIS SECTION, INDIVIDUALS MAY ESTABLISH CREDITABLE COVERAGE THROUGH THE PRESENTATION OF DOCUMENTS OR OTHER MEANS. IN ORDER TO MAKE A DETERMINATION THAT IS BASED ON THE RELEVANT FACTS AND CIRCUMSTANCES OF THE AMOUNT OF CREDITABLE COVERAGE THAT AN INDIVIDUAL HAS, THE STATE HEALTH INSURANCE PLAN FOR UNINSURABLE INDIVIDUALS SHALL TAKE INTO ACCOUNT ALL

INFORMATION THAT THE INSURER OBTAINS OR THAT IS PRESENTED TO THE INSURER ON BEHALF OF THE INDIVIDUAL.

L. THE STATE HEALTH INSURANCE PLAN FOR UNINSURABLE INDIVIDUALS SHALL CALCULATE CREDITABLE COVERAGE ACCORDING TO THE RULES DESCRIBED IN SECTION 20-3214.

M. THIS SECTION APPLIES TO ALL HEALTH INSURANCE COVERAGE THAT IS OFFERED, SOLD, ISSUED, RENEWED, IN EFFECT OR OPERATED IN THE INDIVIDUAL MARKET AFTER JUNE 30, 1997, REGARDLESS OF WHEN A PERIOD OF CREDITABLE COVERAGE OCCURS.

N. FOR THE PURPOSES OF THIS SECTION:

1. "BONA FIDE ASSOCIATION" MEANS, FOR HEALTH CARE COVERAGE ISSUED BY A HEALTH CARE INSURER, AN ASSOCIATION THAT MEETS THE REQUIREMENTS OF SECTION 20-2324.

2. "CREDITABLE COVERAGE" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-3201.

3. "GENETIC INFORMATION" MEANS INFORMATION ABOUT GENES, GENE PRODUCTS AND INHERITED CHARACTERISTICS THAT MAY DERIVE FROM THE INDIVIDUAL OR A FAMILY MEMBER, INCLUDING INFORMATION REGARDING CARRIER STATUS AND INFORMATION DERIVED FROM LABORATORY TESTS THAT IDENTIFY MUTATIONS IN SPECIFIC GENES OR CHROMOSOMES, PHYSICAL MEDICAL EXAMINATIONS, FAMILY HISTORIES AND DIRECT ANALYSES OF GENES OR CHROMOSOMES.

4. "HEALTH CARE INSURER" MEANS A DISABILITY INSURER, GROUP DISABILITY INSURER, BLANKET DISABILITY INSURER, HEALTH CARE SERVICES ORGANIZATION, HOSPITAL SERVICE CORPORATION, MEDICAL SERVICE CORPORATION OR HOSPITAL, MEDICAL, DENTAL AND OPTOMETRIC SERVICE CORPORATION.

5. "HEALTH STATUS-RELATED FACTOR" MEANS ANY FACTOR IN RELATION TO THE HEALTH OF THE INDIVIDUAL OR A DEPENDENT OF THE INDIVIDUAL ENROLLED OR TO BE ENROLLED IN A HEALTH CARE INSURER, INCLUDING:

(a) HEALTH STATUS.

(b) A MEDICAL CONDITION, INCLUDING PHYSICAL AND MENTAL ILLNESS.

(c) CLAIMS EXPERIENCE.

(d) RECEIPT OF HEALTH CARE.

(e) MEDICAL HISTORY.

(f) GENETIC INFORMATION.

(g) EVIDENCE OF INSURABILITY, INCLUDING CONDITIONS ARISING OUT OF ACTS OF DOMESTIC VIOLENCE AS DEFINED IN SECTION 20-448.

(h) THE EXISTENCE OF A PHYSICAL OR MENTAL DISABILITY.

6. "INDIVIDUAL HEALTH INSURANCE COVERAGE" MEANS HEALTH INSURANCE COVERAGE OFFERED BY A HEALTH CARE INSURER TO INDIVIDUALS IN THE INDIVIDUAL MARKET BUT DOES NOT INCLUDE LIMITED BENEFIT COVERAGE OR SHORT-TERM LIMITED DURATION INSURANCE. A HEALTH CARE INSURER THAT OFFERS LIMITED BENEFIT COVERAGE OR SHORT-TERM LIMITED DURATION INSURANCE TO INDIVIDUALS AND NO OTHER COVERAGE TO INDIVIDUALS IN THE INDIVIDUAL MARKET IS NOT A HEALTH CARE INSURER THAT OFFERS HEALTH INSURANCE COVERAGE IN THE INDIVIDUAL MARKET.

7. "LIMITED BENEFIT COVERAGE" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-1137.

8. "NETWORK PLAN" MEANS A HEALTH CARE PLAN PROVIDED BY A HEALTH CARE INSURER UNDER WHICH THE FINANCING AND DELIVERY OF HEALTH CARE SERVICES ARE PROVIDED, IN WHOLE OR IN PART, THROUGH A DEFINED SET OF PROVIDERS UNDER CONTRACT WITH THE HEALTH CARE INSURER PURSUANT TO THE DETERMINATION MADE BY THE DIRECTOR PURSUANT TO SECTION 20-1053 REGARDING THE GEOGRAPHIC OR SERVICE AREA IN WHICH A HEALTH CARE INSURER MAY OPERATE.

9. "SHORT-TERM LIMITED DURATION INSURANCE" MEANS HEALTH INSURANCE COVERAGE THAT IS OFFERED BY A HEALTH CARE INSURER, THAT REMAINS IN EFFECT FOR NO MORE THAN ONE HUNDRED EIGHTY-FIVE DAYS, THAT CANNOT BE RENEWED OR OTHERWISE CONTINUED FOR MORE THAN ONE HUNDRED EIGHTY DAYS AND THAT IS NOT INTENDED OR MARKETED AS HEALTH INSURANCE COVERAGE SUBJECT TO GUARANTEED ISSUANCE OR GUARANTEED RENEWAL PROVISIONS OF THE LAWS OF THIS STATE BUT THAT IS CREDITABLE COVERAGE WITHIN THE MEANING OF THIS SECTION AND SECTION 20-2301.

Sec. 13. Delayed repeal

Sections 20-1381 and 20-1382, Arizona Revised Statutes, are repealed from and after June 30, 2007.

Sec. 14. Section 20-1408, Arizona Revised Statutes, is amended to read:

20-1408. Right to obtain individual policy; requirements; exceptions; definition

A. Each group disability insurance policy delivered or issued for delivery in this state shall provide for the right of all persons covered under the group contract to convert to an individual disability policy on the death of the named insured, the entry of a decree of dissolution of marriage or any other condition other than the failure of the insured to pay the required premium specifically stated in the policy under which coverage would otherwise terminate as to a covered spouse or covered dependent children of the named insured.

B. All persons exercising their right to an individual disability policy under subsection A OF THIS SECTION are entitled to have an individual disability policy issued to them by the issuer on a form provided for conversion which provides coverage most similar to that provided under the group policy. Each person entitled to have a conversion policy issued to him may elect a lesser form of coverage.

C. A written application and the first premium payment for the converted policy shall be made to the insurer within thirty-one days following termination of coverage under the existing policy. A monthly premium rate shall be offered to the person exercising continuation or conversion rights, and payment of one monthly premium shall be deemed sufficient consideration to enact the continuation or conversion policy. The effective date of the conversion policy is the day following the termination of insurance under the group policy.

D. Coverage provided through the conversion policy shall be without additional evidence of insurability and shall not impose any preexisting condition limitations, exclusions or other contractual time limitations other than those remaining unexpired under the policy or contract from which conversion is exercised.

E. Conversion of coverage may INCLUDE, at the option of the spouse exercising the right, ~~include~~ covered dependent children for whom the spouse has responsibility for care or support.

F. The insurer may elect to provide group insurance coverage in lieu of the issuance of a converted individual policy.

G. Each certificate of coverage shall include notice of the conversion privilege.

H. This section does not apply to disability income policies, to accidental death or dismemberment policies or to single term nonrenewable policies.

I. Conversion is not available to a person eligible for medicare or eligible for or covered by other similar disability benefits which together with the conversion coverage would constitute overinsurance.

J. At the time of filing a petition for dissolution of marriage, the clerk of the court shall provide to the petitioner for a dissolution of marriage two copies of the notice of the right of a dependent spouse to convert health insurance coverage under this section. The petitioner shall cause one copy of the notice to be served on the respondent together with a copy of the petition, summons and preliminary injunction. The director shall prepare the notice which must include a summary of this section. The clerk of the court or the director is not liable for damages arising from information contained in or omitted from the notices prepared or provided under this section.

K. This section also applies to blanket accident and sickness insurance policies and to all disability insurance issued by hospital, medical, dental and optometric service corporations, health care services organizations and fraternal benefit societies.

L. Any person who is a United States armed forces reservist, who is ordered to active military duty on or after August 22, 1990 and who had coverage under a disability insurance policy provided by the person's employer at such time shall have the right to reinstate such coverage upon release from active military duty subject to the following conditions:

1. Following reemployment by the reservist's former employer, the reservist shall make written application to the insurer within ninety days of discharge from active military duty or within one year of hospitalization continuing after discharge. Coverage shall be effective upon receipt of application by the insurer.

2. The coverage reinstated shall be the same coverage provided by the employer to other employees and their dependents in the employer group health insurance plan at the time of application.

3. The insurer may exclude from such coverage any health or physical condition arising during and occurring as a direct result of active military duty.

M. Each dependent of a person eligible for reinstatement under SUBSECTION L OF this ~~provision~~ SECTION shall be afforded the same rights and be subject to the same conditions as the insured, if the dependent was insured under the disability insurance policy at the time the eligible person entered active duty. Any dependent of such person born during the period of active military duty shall have the same rights as other dependents noted in this ~~section~~ SUBSECTION.

N. The director shall adopt emergency rules applicable to persons who are leaving active service in the armed forces of the United States and returning to civilian status consistent with ~~the provisions of~~ subsection L of this section, including:

1. Conditions of eligibility.
2. Coverage of dependents.
3. Preexisting conditions.
4. Termination of insurance.
5. Probationary periods.
6. Limitations.
7. Exceptions.
8. Reductions.
9. Elimination periods.
10. Requirements for replacement.
11. Any other conditions of group and blanket disability contracts.

O. A group policy or any conversion policy that is issued under this section shall not be cancelled or nonrenewed except if:

1. The individual has failed to pay premiums or contributions pursuant to the terms of the health insurance coverage or the insurer has not received premium payments in a timely manner.
2. The individual has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact under the terms of the coverage.
3. The insurer has ceased to offer coverage to individuals that is consistent with the requirements of ~~sections 20-1379 and~~ SECTION 20-1380.
4. In the case of an insurer that offers health care coverage in this state through a network plan, no member of the group resides, lives or works in the service area served by the network plan or in an area for which the insurer is authorized to transact business but only if the coverage is terminated uniformly without regard to any health status-related factor of any covered individual.
5. In the case of an insurer who offers health coverage in the group market only through one or more bona fide associations, the membership of an employer in the association has ceased but only if that coverage is

terminated uniformly without regard to any health status-related factor or any covered individual.

P. A conversion policy may be modified if the modification complies with the notice and disclosure requirements set forth in the group policy and evidence of coverage. A modification of a conversion policy which has already been issued to an insured shall not result in the effective elimination of any benefit originally included in the conversion policy.

Q. For the purposes of this section, "network plan" means a health care plan provided by an insurer under which the financing and delivery of health care services are provided, in whole or in part, through a defined set of providers under contract with the insurer.

Sec. 15. Section 20-1412, Arizona Revised Statutes, is amended to read:

20-1412. Group and blanket disability insurance policies or contracts; varying copayments and deductibles allowed

A. Except as provided in ~~sections 20-1379 and~~ SECTION 20-2304, a group disability insurer or a blanket disability insurer may offer one or more disability insurance policies or contracts that contain a choice of deductibles, coinsurance, copayments~~,~~ AND out-of-pocket and any other cost sharing levels. Plans offered under this section shall clearly disclose in marketing materials, certificates of coverage and contracts the insured's financial responsibilities. A group disability insurer or blanket disability insurer that offers such a disability insurance policy or contract shall continue to provide any mandated health coverage that is required by this state or by federal law.

B. This section does not prohibit a health benefits plan that is intended to qualify as a high deductible health plan as defined by 26 United States Code section 223 (c)(2) from requiring the application of deductibles, copayments or coinsurance to benefits provided under the health benefits plan.

Sec. 16. Section 20-2308, Arizona Revised Statutes, is amended to read:

20-2308. Portability

A newborn child, adopted child or child placed for adoption is an eligible individual if the child was timely enrolled and otherwise would have met the definition of an eligible individual as prescribed in section ~~20-1379~~ 20-3205 other than the required period of creditable coverage and the child ~~is not~~ IS NOT subject to any preexisting condition exclusion or limitation if the child has been continuously covered under health insurance coverage or a health benefits plan offered by an accountable health plan since birth, adoption or placement for adoption.

Sec. 17. Section 20-2310, Arizona Revised Statutes, is amended to read:

20-2310. Discrimination prohibited; preexisting conditions

A. Except as provided in subsection B of this section, a health benefits plan may not deny, limit or condition the coverage or benefits based on a person's health status-related factors or a lack of evidence of insurability.

B. A health benefits plan shall not exclude coverage for preexisting conditions, except that:

1. A health benefits plan may exclude coverage for preexisting conditions for a period of not more than twelve months or, in the case of a late enrollee, eighteen months. The exclusion of coverage does not apply to services that are furnished to newborns who were otherwise covered from the time of their birth or to persons who satisfy the portability requirements under section 20-2308.

2. The accountable health plan shall reduce the period of any applicable preexisting condition exclusion by the aggregate of the periods of creditable coverage that apply to the individual.

C. A health benefits plan shall not include an affiliation period in a policy unless the affiliation period satisfies the requirements prescribed in 45 Code of Federal Regulations section 146.119(b).

D. On request of a health benefits plan, a person who provides coverage during a period of continuous coverage with respect to a covered individual shall promptly disclose the coverage provided to the covered individual, the period of the coverage and the benefits provided under the coverage.

E. The accountable health plan shall calculate creditable coverage according to the following rules:

1. The accountable health plan shall give an individual credit for each day the individual was covered by creditable coverage.

2. The accountable health plan shall not count a period of creditable coverage for an individual enrolled in a health benefits plan if after the period of coverage and before the enrollment date there were sixty-three consecutive days during which the individual was not covered under any creditable coverage.

3. The accountable health plan shall give credit in the calculation of creditable coverage for any period that an individual is in a waiting period or an affiliation period for any health coverage.

4. The accountable health plan shall not count a period of creditable coverage with respect to enrollment of an individual if, after the most recent period of creditable coverage and before the enrollment date, sixty-three consecutive days lapse during all of which the individual was not covered under any creditable coverage. The accountable health plan shall not include in the determination of the period of continuous coverage described in this section any period that an individual is in a waiting period for

health insurance coverage offered by a health care insurer, is in a waiting period for benefits under a health benefits plan offered by an accountable health plan or is in an affiliation period.

5. In determining the extent to which an individual has satisfied any portion of any applicable preexisting condition period the accountable health plan shall count a period of creditable coverage without regard to the specific benefits covered during that period.

6. An accountable health plan shall not impose any preexisting condition exclusion in the case of an individual who is covered under creditable coverage thirty-one days after the individual's date of birth.

7. An accountable health plan shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before age eighteen and who is covered under creditable coverage thirty-one days after the adoption or placement for adoption.

F. An accountable health plan shall provide the certificate of creditable coverage described in subsection G of this section without charge for creditable coverage occurring after June 30, 1996 if the individual:

1. Ceases to be covered under a health benefits plan offered by an accountable health plan or otherwise becomes covered under a COBRA continuation provision. An individual who is covered by a health benefits plan that is offered by an accountable health plan, that is terminated or not renewed at the choice of the employer and where the replacement of the health benefits plan is without a break in coverage is not entitled to receive the certification prescribed in this paragraph but is instead entitled to receive the certifications prescribed in paragraphs 2 and 3 of this subsection.

2. Who was covered under a COBRA continuation provision ceases to be covered under the COBRA continuation provision.

3. Requests certification from the accountable health plan within twenty-four months after the coverage under a health benefits plan offered by an accountable health plan ceases.

G. The certificate of creditable coverage provided by an accountable health plan is a written certification of:

1. The period of creditable coverage of the individual under the accountable health plan and any applicable coverage under a COBRA continuation provision.

2. Any applicable waiting period or affiliation period imposed on an individual for any coverage under the accountable health plan.

H. Any accountable health plan that issues health benefits plans in this state, as applicable, shall issue and accept a written certificate of creditable coverage of the individual that contains at least the following information:

1. The date that the certificate is issued.

2. The name of the individual or dependent for whom the certificate applies and any other information that is necessary to allow the issuer providing the coverage specified in the certificate to identify the

individual, including the individual's identification number under the policy and the name of the policyholder if the certificate is for or includes a dependent.

3. The name, address and telephone number of the issuer providing the certificate.

4. The telephone number to call for further information regarding the certificate.

5. One of the following:

(a) A statement that the individual has at least eighteen months of creditable coverage. For THE purposes of this subdivision, "eighteen months" means five hundred forty-six days.

(b) Both the date that the individual first sought coverage, as evidenced by a substantially complete application, and the date that creditable coverage began.

6. The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing from the date of the certificate.

7. The consumer assistance telephone number for the department.

8. The following statement in at least fourteen point type:

Important notice!

Keep this certificate with your important personal records to protect your rights under the health insurance portability and accountability act of 1996 ("HIPAA"). This certificate is proof of your prior health insurance coverage. You may need to show this certificate to have a guaranteed right to buy new health insurance FROM THE STATE HEALTH INSURANCE PLAN FOR UNINSURABLE INDIVIDUALS ("Guaranteed issue"). This certificate may also help you avoid waiting periods or exclusions for preexisting conditions. Under HIPAA, these rights are guaranteed only for a very short time period. After your group coverage ends, you must apply for new coverage within ~~63~~ SIXTY-THREE days to be protected by HIPAA. If you have questions, call the Arizona department of insurance.

I. An accountable health plan may provide any certification pursuant to subsection F, paragraph 1 of this section at the same time the accountable health plan sends the notice required by the applicable COBRA continuation provision.

J. An accountable health plan has satisfied the certification requirement under this section if the accountable health plan offering the health benefits plan provides the prescribed certificate in accordance with this section within thirty days after the event that triggered the issuance of the certification.

K. If an accountable health plan imposes a waiting period for coverage of preexisting conditions, within a reasonable period of time after receiving an individual's proof of creditable coverage and not later than the date by

which the individual must select an insurance plan, the accountable health plan shall give the individual written disclosure of the accountable health plan's determination regarding any preexisting condition exclusion period that applies to that individual. The disclosure shall include all of the following information:

1. The period of creditable coverage allowed toward the waiting period for coverage of preexisting conditions.

2. The basis for the accountable health plan's determination and the source and substance of any information on which the accountable health plan has relied.

3. A statement of any right the individual may have to present additional evidence of creditable coverage and to appeal the accountable health plan's determination, including an explanation of any procedures for submission and appeal.

L. Periods of creditable coverage for an individual are established by presentation of the written certifications described in this section and section ~~20-1379~~ 20-3214. In addition to written certification of the period of creditable coverage as described in this section, individuals may establish creditable coverage through the presentation of documents or other means. In order to make a determination that is based on the relevant facts and circumstances of the amount of creditable coverage that an individual has, an accountable health plan shall take into account all information that the plan obtains or that is presented to the plan on behalf of the individual.

M. The department may enforce and monitor the issuance and delivery of the notices and certificates by accountable health plans and insurers as required by this section, the health insurance portability and accountability act of 1996 (P.L. 104-191; 110 Stat. 1936) and any federal regulations adopted to implement the health insurance portability and accountability act of 1996.

Sec. 18. Section 20-2331, Arizona Revised Statutes, is amended to read:

20-2331. Accountable health plans; varying copayments and deductibles allowed

A. Except as provided in ~~sections 20-1379 and~~ SECTION 20-2304, an accountable health plan may offer one or more health benefits plans that contain a choice of deductibles, coinsurance, copayments~~,~~ AND out-of-pocket and any other cost sharing levels. Plans offered under this section shall clearly disclose in marketing materials, certificates of coverage and contracts the insured's financial responsibilities. An accountable health plan that offers such a health benefit plan shall continue to provide any mandated health coverage that is required by this state or by federal law.

B. This section does not prohibit a health benefits plan that is intended to qualify as a high deductible health plan as defined by 26 United States Code section 223 (c)(2) from requiring the application of deductibles,

copayments or coinsurance to benefits provided under the health benefits plan.

Sec. 19. Title 20, Arizona Revised Statutes, is amended by adding chapter 22, to read:

CHAPTER 22

STATE HEALTH INSURANCE PLAN FOR UNINSURABLE INDIVIDUALS

ARTICLE 1. GENERAL PROVISIONS

20-3201. Definitions

IN THIS CHAPTER, UNLESS THE CONTEXT OTHERWISE REQUIRES:

1. "AFFILIATION PERIOD" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-2301.

2. "BOARD" MEANS THE BOARD OF DIRECTORS OF THE PLAN.

3. "BONA FIDE ASSOCIATION" MEANS, FOR HEALTH CARE COVERAGE ISSUED BY A HEALTH CARE INSURER, AN ASSOCIATION THAT MEETS THE REQUIREMENTS OF SECTION 20-2324.

4. "CHURCH PLAN" HAS THE SAME MEANING PRESCRIBED BY ERISA.

5. "CREDITABLE COVERAGE" MEANS COVERAGE, OTHER THAN LIMITED BENEFIT COVERAGE AS DEFINED IN SECTION 20-1137, SOLELY FOR AN INDIVIDUAL UNDER ANY OF THE FOLLOWING:

(a) AN EMPLOYEE WELFARE BENEFIT PLAN THAT PROVIDES MEDICAL CARE TO EMPLOYEES OR THE EMPLOYEES' DEPENDENTS DIRECTLY OR THROUGH INSURANCE OR REIMBURSEMENT OR OTHERWISE PURSUANT TO ERISA.

(b) A CHURCH PLAN.

(c) A HEALTH BENEFITS PLAN ISSUED BY AN ACCOUNTABLE HEALTH PLAN AS DEFINED IN SECTION 20-2301.

(d) MEDICARE.

(e) TITLE XIX OF THE SOCIAL SECURITY ACT, OTHER THAN COVERAGE CONSISTING SOLELY OF BENEFITS UNDER SECTION 1928.

(f) TITLE 10, CHAPTER 55 OF THE UNITED STATES CODE.

(g) A MEDICAL CARE PROGRAM OF THE INDIAN HEALTH SERVICE OR OF A TRIBAL ORGANIZATION.

(h) A HEALTH BENEFITS RISK POOL OPERATED BY ANY STATE OF THE UNITED STATES.

(i) A HEALTH PLAN OFFERED PURSUANT TO TITLE 5, CHAPTER 89 OF THE UNITED STATES CODE.

(j) A PUBLIC HEALTH PLAN AS DEFINED BY FEDERAL LAW.

(k) A HEALTH BENEFIT PLAN PURSUANT TO SECTION 5(e) OF THE PEACE CORPS ACT (P.L. 87-293; 75 STAT. 612; 22 UNITED STATES CODE SECTIONS 2501 THROUGH 2523).

(l) A POLICY OR CONTRACT, INCLUDING SHORT-TERM LIMITED DURATION INSURANCE, ISSUED ON AN INDIVIDUAL BASIS BY AN INSURER, A HEALTH CARE SERVICES ORGANIZATION, A HOSPITAL SERVICE CORPORATION, A MEDICAL SERVICE CORPORATION OR A HOSPITAL, MEDICAL, DENTAL AND OPTOMETRIC SERVICE CORPORATION OR MADE AVAILABLE TO PERSONS DEFINED AS ELIGIBLE UNDER SECTION 36-2901, PARAGRAPH 6, SUBDIVISION (b), (c), (d) OR (e).

(m) A POLICY OR CONTRACT ISSUED BY A HEALTH CARE INSURER OR AN ACCOUNTABLE HEALTH PLAN TO A MEMBER OF A BONA FIDE ASSOCIATION.

(n) THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM ESTABLISHED BY TITLE XXI OF THE SOCIAL SECURITY ACT.

6. "DELINQUENCY PROCEEDING" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-611.

7. "DEPARTMENT" MEANS THE DEPARTMENT OF INSURANCE.

8. "DEPENDENT" MEANS ANY OF THE FOLLOWING:

(a) A RESIDENT SPOUSE.

(b) A RESIDENT UNMARRIED CHILD WHO IS UNDER NINETEEN YEARS OF AGE.

(c) A RESIDENT CHILD WHO IS A STUDENT, UNDER TWENTY-THREE YEARS OF AGE AND FINANCIALLY DEPENDENT ON THE PARENT.

(d) A RESIDENT CHILD WHO IS AT LEAST NINETEEN YEARS OF AGE AND WHO IS AND CONTINUES TO BE BOTH INCAPABLE OF SELF-SUSTAINING EMPLOYMENT BY REASON OF MENTAL RETARDATION OR PHYSICAL HANDICAP AND CHIEFLY DEPENDENT ON THE PARENT FOR SUPPORT OR MAINTENANCE.

9. "ENROLLMENT DATE" MEANS THE FIRST DAY OF COVERAGE OR, IF THERE IS A WAITING PERIOD, THE FIRST DAY OF THE WAITING PERIOD. THE FIRST DAY OF COVERAGE FOR AN INDIVIDUAL ENROLLING IN A GROUP PLAN IS THE FIRST DAY OF COVERAGE UNDER THE GROUP HEALTH PLAN. THE FIRST DAY OF COVERAGE IN THE CASE OF AN INDIVIDUAL COVERED BY HEALTH INSURANCE IN THE INDIVIDUAL MARKET IS THE FIRST DAY OF COVERAGE UNDER THE POLICY OR CONTRACT.

10. "ERISA" MEANS THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (P.L. 93-406; 88 STAT. 829; 29 UNITED STATES CODE SECTIONS 1001 THROUGH 1461).

11. "GENETIC INFORMATION" MEANS INFORMATION ABOUT GENES, GENE PRODUCTS AND INHERITED CHARACTERISTICS THAT MAY DERIVE FROM THE INDIVIDUAL OR A FAMILY MEMBER, INCLUDING INFORMATION REGARDING CARRIER STATUS AND INFORMATION DERIVED FROM LABORATORY TESTS THAT IDENTIFY MUTATIONS IN SPECIFIC GENES OR CHROMOSOMES, PHYSICAL MEDICAL EXAMINATIONS, FAMILY HISTORIES AND DIRECT ANALYSES OF GENES OR CHROMOSOMES.

12. "GOVERNMENT PLAN" HAS THE SAME MEANING PRESCRIBED BY ERISA AND ANY FEDERAL GOVERNMENT PLAN.

13. "GROUP HEALTH PLAN" MEANS AN EMPLOYEE WELFARE BENEFIT PLAN AS DEFINED IN SECTION 3 (1) OF ERISA TO THE EXTENT THAT THE PLAN PROVIDES MEDICAL CARE AND INCLUDING ITEMS AND SERVICES PAID FOR AS MEDICAL CARE TO EMPLOYEES OR THEIR DEPENDENTS AS DEFINED UNDER THE TERMS OF THE PLAN DIRECTLY OR THROUGH INSURANCE OR REIMBURSEMENT OR OTHERWISE.

14. "HEALTH CARE INSURER" MEANS A DISABILITY INSURER, GROUP DISABILITY INSURER, BLANKET DISABILITY INSURER, HEALTH CARE SERVICES ORGANIZATION, ACCOUNTABLE HEALTH PLAN, HOSPITAL SERVICE CORPORATION, MEDICAL SERVICE CORPORATION OR HOSPITAL, MEDICAL, DENTAL AND OPTOMETRIC SERVICE CORPORATION THAT PROVIDES HEALTH INSURANCE IN THIS STATE.

15. "HEALTH CARE PLAN" MEANS A HEALTH CARE INSURER THAT OFFERS HEALTH INSURANCE OR A SELF-INSURED HEALTH PLAN. HEALTH CARE PLAN DOES NOT INCLUDE

MEDICARE, MEDICAID OR ANY GOVERNMENTAL PLAN, EXCEPT A PLAN ESTABLISHED OR MAINTAINED FOR ITS EMPLOYEES BY THE GOVERNMENT OF THE UNITED STATES OR BY ANY AGENCY OR INSTRUMENTALITY OF THE UNITED STATES.

16. "HEALTH INSURANCE" MEANS A LICENSED HEALTH CARE PLAN OR ARRANGEMENT THAT PAYS FOR OR FURNISHES MEDICAL OR HEALTH CARE SERVICES AND THAT IS ISSUED BY A HEALTH CARE INSURER. HEALTH INSURANCE DOES NOT INCLUDE LONG-TERM CARE INSURANCE, LIMITED BENEFIT COVERAGE AS DEFINED IN SECTION 20-1137, SHORT-TERM INSURANCE, CREDIT INSURANCE, COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY INSURANCE, INSURANCE ARISING OUT OF WORKERS' COMPENSATION COVERAGE, AUTOMOBILE MEDICAL PAYMENTS COVERAGE OR INSURANCE UNDER WHICH BENEFITS ARE PAYABLE WITH OR WITHOUT REGARD TO FAULT AND THAT IS STATUTORILY REQUIRED TO BE CONTAINED IN ANY LIABILITY INSURANCE POLICY OR EQUIVALENT SELF-INSURANCE.

17. "MEDICAL CARE" MEANS AMOUNTS PAID FOR ANY OF THE FOLLOWING:

(a) THE DIAGNOSIS, CARE, MITIGATION, TREATMENT OR PREVENTION OF DISEASE OR AMOUNTS PAID FOR THE PURPOSE OF AFFECTING ANY STRUCTURE OR FUNCTION OF THE HUMAN BODY.

(b) TRANSPORTATION PRIMARILY FOR AND ESSENTIAL TO MEDICAL CARE UNDER SUBDIVISION (a) OF THIS PARAGRAPH.

(c) INSURANCE COVERING MEDICAL CARE UNDER SUBDIVISIONS (a) AND (b) OF THIS PARAGRAPH.

18. "MEDICARE" MEANS COVERAGE UNDER BOTH PARTS A AND B OF TITLE XVIII OF THE SOCIAL SECURITY ACT (42 UNITED STATES CODE SECTIONS 1395 THROUGH 1395ggg), AS AMENDED.

19. "PLAN" MEANS THE STATE HEALTH INSURANCE PLAN FOR UNINSURABLE INDIVIDUALS.

20. "PREEXISTING CONDITION" MEANS A PHYSICAL OR MENTAL CONDITION, REGARDLESS OF THE CAUSE OF THE CONDITION, FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WAS RECOMMENDED OR RECEIVED WITHIN THE TWENTY-FOUR MONTH PERIOD ENDING ON THE ENROLLMENT DATE.

21. "PREEXISTING CONDITION EXCLUSION" MEANS A LIMITATION OR EXCLUSION OF BENEFITS RELATING TO A PREEXISTING CONDITION BASED ON THE FACT THAT THE CONDITION WAS PRESENT BEFORE THE FIRST DAY OF COVERAGE, WHETHER OR NOT ANY TREATMENT WAS RECOMMENDED OR RECEIVED BEFORE THAT DAY. A PREEXISTING CONDITION EXCLUSION INCLUDES ANY EXCLUSION APPLICABLE TO AN INDIVIDUAL AS A RESULT OF A PRE-ENROLLMENT QUESTIONNAIRE OR PHYSICAL EXAMINATION GIVEN TO THE INDIVIDUAL, OR A REVIEW OF MEDICAL RECORDS RELATING TO THE PRE-ENROLLMENT PERIOD.

22. "RESIDENT" MEANS AN INDIVIDUAL WHO IS LEGALLY DOMICILED IN THIS STATE FOR A PERIOD OF AT LEAST THIRTY DAYS, EXCEPT THAT FOR AN ELIGIBLE INDIVIDUAL, THE THIRTY DAY REQUIREMENT DOES NOT APPLY.

23. "SHORT-TERM LIMITED DURATION INSURANCE" MEANS HEALTH INSURANCE COVERAGE THAT IS OFFERED BY A HEALTH CARE INSURER, THAT REMAINS IN EFFECT FOR NO MORE THAN ONE HUNDRED EIGHTY-FIVE DAYS, THAT CANNOT BE RENEWED OR OTHERWISE CONTINUED FOR MORE THAN ONE HUNDRED EIGHTY DAYS AND THAT IS NOT INTENDED OR MARKETED AS HEALTH INSURANCE COVERAGE SUBJECT TO GUARANTEED

RENEWAL PROVISIONS OF THE LAWS OF THIS STATE BUT THAT IS CREDITABLE COVERAGE WITHIN THE MEANING OF THIS SECTION AND SECTION 20-2301.

24. "SIGNIFICANT BREAK IN COVERAGE" MEANS A PERIOD OF SIXTY-THREE CONSECUTIVE DAYS DURING ALL OF WHICH THE INDIVIDUAL DOES NOT HAVE ANY CREDITABLE COVERAGE, EXCEPT THAT NEITHER A WAITING PERIOD NOR AN AFFILIATION PERIOD IS TAKEN INTO ACCOUNT IN DETERMINING A SIGNIFICANT BREAK IN COVERAGE.

25. "WAITING PERIOD" MEANS, FOR A PERSON SEEKING COVERAGE UNDER A GROUP HEALTH PLAN, THE PERIOD THAT MUST PASS BEFORE COVERAGE FOR AN EMPLOYEE OR DEPENDENT WHO IS OTHERWISE ELIGIBLE TO ENROLL CAN BECOME EFFECTIVE. IN THE INDIVIDUAL MARKET, A WAITING PERIOD BEGINS ON THE DATE THE INDIVIDUAL SUBMITS A SUBSTANTIALLY COMPLETE APPLICATION FOR COVERAGE. IN THE INDIVIDUAL MARKET, THE WAITING PERIOD ENDS IN THE CASE OF AN APPLICATION THAT RESULTS IN COVERAGE, THE DATE COVERAGE BEGINS. IN THE CASE OF AN APPLICATION THAT DOES NOT RESULT IN COVERAGE, THE WAITING PERIOD ENDS ON THE DATE THE APPLICATION IS DENIED BY THE ISSUER OR THE DATE THE OFFER OF COVERAGE LAPSES.

20-3202. State health insurance plan for uninsurable individuals; board of directors; appointment; term

A. THE STATE HEALTH INSURANCE PLAN FOR UNINSURABLE INDIVIDUALS IS ESTABLISHED IN THE DEPARTMENT OF INSURANCE. THE PLAN OPERATES UNDER THE SUPERVISION AND CONTROL OF THE BOARD OF DIRECTORS.

B. THE BOARD CONSISTS OF THE FOLLOWING:

1. THREE NONVOTING MEMBERS, WHO ARE NOT COUNTED FOR THE PURPOSE OF DETERMINING A QUORUM, CONSISTING OF:

(a) THE DIRECTOR OF THE DEPARTMENT OF INSURANCE.

(b) ONE PERSON WHO IS APPOINTED BY THE SPEAKER OF THE HOUSE OF REPRESENTATIVES.

(c) ONE PERSON WHO IS APPOINTED BY THE PRESIDENT OF THE SENATE

2. SEVEN VOTING MEMBERS, WHO ARE APPOINTED BY THE GOVERNOR ON THE RECOMMENDATION OF THE DIRECTOR OF THE DEPARTMENT, CONSISTING OF:

(a) THREE MEMBERS REPRESENTING INSURERS, ONE OF WHOM MUST BE AN ACTUARY.

(b) ONE MEMBER REPRESENTING BROKERS.

(c) ONE MEMBER REPRESENTING THE PUBLIC.

(d) TWO MEMBERS REPRESENTING HEALTH CARE PROVIDERS.

C. VOTING BOARD MEMBERS SERVE FOR A FIVE-YEAR TERM. MEMBERS OF THE BOARD SHALL ELECT A CHAIRMAN AND CO-CHAIRMAN.

D. VOTING BOARD MEMBERS ARE NOT ELIGIBLE TO RECEIVE COMPENSATION BUT ARE ELIGIBLE FOR REIMBURSEMENT OF EXPENSES PURSUANT TO TITLE 38, CHAPTER 4, ARTICLE 2.

20-3203. Plan of operation

A. THE BOARD SHALL ADOPT A PLAN OF OPERATION FOR THE PLAN AND ANY AMENDMENTS TO THE PLAN.

B. THE PLAN OF OPERATION SHALL PRESCRIBE:

1. OPERATING PROCEDURES.

2. PROCEDURES FOR SELECTING AN ADMINISTRATOR AS PROVIDED IN SECTION 20-3210.

3. PROCEDURES TO ESTABLISH AN ADMINISTRATIVE EXPENSE FUND UNDER THE BOARD'S MANAGEMENT.

4. PROCEDURES FOR THE HANDLING, ACCOUNTING AND AUDITING OF ASSETS, MONIES AND CLAIMS OF THE PLAN AND THE PLAN ADMINISTRATOR.

5. THE DEVELOPMENT AND IMPLEMENTATION OF A PROGRAM TO CREATE AND MAINTAIN PUBLIC AWARENESS OF THE PLAN.

6. PROCEDURES UNDER WHICH APPLICANTS AND PARTICIPANTS MAY HAVE GRIEVANCES REVIEWED BY A GRIEVANCE COMMITTEE THAT IS APPOINTED BY THE BOARD. THE GRIEVANCES SHALL BE REPORTED TO THE BOARD AFTER COMPLETION OF THE REVIEW. THE BOARD SHALL RETAIN ALL WRITTEN COMPLAINTS REGARDING THE PLAN FOR AT LEAST THREE YEARS.

7. OTHER MATTERS THAT MAY BE NECESSARY AND PROPER FOR THE EXECUTION OF THE BOARD'S POWERS, DUTIES AND OBLIGATIONS.

20-3204. Powers and duties of the board; annual report; immunity

A. THE BOARD HAS THE GENERAL POWERS AND AUTHORITY GRANTED UNDER THE LAWS OF THIS STATE TO HEALTH INSURERS AND THE SPECIFIC AUTHORITY TO:

1. CARRY OUT THE PROVISIONS AND PURPOSES OF THE PLAN, INCLUDING THE AUTHORITY TO ENTER INTO CONTRACTS WITH PERSONS OR OTHER ORGANIZATIONS FOR THE PERFORMANCE OF ADMINISTRATIVE FUNCTIONS.

2. SUE OR BE SUED, INCLUDING ANY LEGAL ACTION TO:

(a) AVOID THE PAYMENT OF IMPROPER CLAIMS AGAINST THE PLAN OR THE COVERAGE PROVIDED BY OR THROUGH THE PLAN.

(b) RECOVER ANY AMOUNTS ERRONEOUSLY OR IMPROPERLY PAID BY THE PLAN.

(c) RECOVER ANY AMOUNTS PAID BY THE PLAN AS A RESULT OF A MISTAKE OF FACT OR LAW.

(d) RECOVER OTHER AMOUNTS DUE THE PLAN.

3. ESTABLISH AND MODIFY RATES, RATE SCHEDULES AND RATE ADJUSTMENTS FOR ELIGIBLE INDIVIDUALS AND DEPENDENTS AND EXPENSE ALLOWANCES, CLAIM RESERVE FORMULAS AND ANY OTHER ACTUARIAL FUNCTION APPROPRIATE TO THE OPERATION OF THE PLAN. THE BOARD MAY ADJUST RATES AND RATE SCHEDULES FOR APPROPRIATE FACTORS SUCH AS AGE, GENDER AND GEOGRAPHIC VARIATION IN CLAIM COST AND SHALL TAKE INTO CONSIDERATION APPROPRIATE FACTORS IN ACCORDANCE WITH THE ESTABLISHED ACTUARIAL AND UNDERWRITING PRACTICES.

4. ISSUE INSURANCE POLICIES.

5. APPOINT APPROPRIATE LEGAL, ACTUARIAL AND OTHER COMMITTEES AS NECESSARY TO PROVIDE TECHNICAL ASSISTANCE IN THE OPERATION OF THE PLAN, POLICY AND OTHER CONTRACT DESIGN AND OTHER FUNCTIONS WITHIN THE AUTHORITY OF THE BOARD.

6. BORROW MONEY TO EFFECT THE PURPOSES OF THE PLAN. ANY NOTES OR OTHER EVIDENCES OF INDEBTEDNESS OF THE PLAN THAT ARE NOT IN DEFAULT ARE LEGAL INVESTMENTS FOR INSURERS AND MAY BE CARRIED AS ADMITTED ASSETS.

7. PROVIDE FOR REINSURANCE OF RISKS INCURRED BY THE PLAN AND ESTABLISH RULES, CONDITIONS AND PROCEDURES FOR REINSURING RISKS.

8. EMPLOY AND DETERMINE THE CONDITIONS OF EMPLOYMENT AND DUTIES OF THE EMPLOYEES. EMPLOYEE COMPENSATION SHALL BE AS PRESCRIBED IN SECTION 38-611. PLAN EMPLOYEES ARE EMPLOYEES OF THE DEPARTMENT. THE BOARD SHALL PAY THEIR SALARIES AND RELATED EXPENSES OUT OF THE STATE HEALTH INSURANCE PLAN FOR UNINSURABLE INDIVIDUALS FUND OR ADMINISTRATIVE SERVICES FUND.

9. PREPARE AND DISTRIBUTE CERTIFICATE OF ELIGIBILITY FORMS AND ENROLLMENT INSTRUCTION FORMS TO INSURANCE PRODUCERS AND THE GENERAL PUBLIC.

10. PROVIDE FOR AND EMPLOY COST CONTAINMENT MEASURES AND REQUIREMENTS.

11. DESIGN OR USE OR CONTRACT OR OTHERWISE ARRANGE FOR THE DELIVERY OF COST-EFFECTIVE HEALTH CARE SERVICES.

12. ADOPT BYLAWS, POLICIES AND PROCEDURES AS NECESSARY OR CONVENIENT FOR THE IMPLEMENTATION AND OPERATION OF THE PLAN.

13. DEVELOP AND ISSUE POLICIES THAT CONFORM TO THE GUARANTEED ISSUANCE REQUIREMENTS OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (P.L. 104-204; 110 STAT. 2944).

B. THE BOARD SHALL SUBMIT AN ANNUAL REPORT TO THE GOVERNOR, THE PRESIDENT OF THE SENATE. THE SPEAKER OF THE HOUSE OF REPRESENTATIVES AND THE DIRECTOR AND SHALL PROVIDE COPIES TO THE SECRETARY OF STATE AND THE DIRECTOR OF THE ARIZONA STATE LIBRARY, ARCHIVES AND PUBLIC RECORDS. THE REPORT SHALL SUMMARIZE THE ACTIVITIES OF THE BOARD IN THE PRECEDING CALENDAR YEAR, INCLUDING THE NET WRITTEN AND EARNED PREMIUMS, PLAN ENROLLMENT, EXPENSE OF ADMINISTRATION AND PAID AND INCURRED LOSSES.

C. THE BOARD AND THE BOARD'S EMPLOYEES ARE NOT LIABLE FOR ANY OBLIGATIONS OF THE PLAN. A MEMBER OR EMPLOYEE OF THE BOARD IS NOT LIABLE AND NO CAUSE OF ACTION OF ANY NATURE MAY ARISE AGAINST THE MEMBER OR EMPLOYEE FOR ANY ACT OR OMISSION RELATED TO THE PERFORMANCE OF THE POWERS AND DUTIES PRESCRIBED IN THIS CHAPTER UNLESS THE ACT OR OMISSION CONSTITUTES WILLFUL OR WANTON MISCONDUCT. THE BOARD MAY PROVIDE IN ITS BYLAWS OR RULES FOR INDEMNIFICATION OF AND LEGAL REPRESENTATION FOR ITS MEMBERS AND EMPLOYEES.

20-3205. Eligibility

FROM AND AFTER JUNE 30, 2007, UNINSURABLE INDIVIDUALS AS DESCRIBED IN SECTION 20-3206 AND FEDERALLY QUALIFIED ELIGIBLE INDIVIDUALS AS DESCRIBED IN SECTION 20-3207 ARE ELIGIBLE FOR PLAN COVERAGE.

20-3206. Eligibility for uninsurable individuals

A. FROM AND AFTER JUNE 30, 2007, AN INDIVIDUAL IS UNINSURABLE AND ELIGIBLE FOR PLAN COVERAGE IF THE INDIVIDUAL IS AND CONTINUES TO BE A RESIDENT OF THIS STATE AND PROVIDES EVIDENCE OF REJECTION OR REFUSAL TO ISSUE HEALTH INSURANCE FOR HEALTH REASONS BY TWO HEALTH CARE INSURERS IN THIS STATE WITHIN THE PAST YEAR. A REJECTION OR REFUSAL BY A HEALTH CARE INSURER THAT OFFERS ONLY STOP LOSS, EXCESS OF LOSS OR REINSURANCE COVERAGE WITH RESPECT TO THE APPLICANT IS NOT SUFFICIENT EVIDENCE OF REJECTION OR REFUSAL.

B. FROM AND AFTER JUNE 30, 2007, AN INDIVIDUAL IS NOT ELIGIBLE FOR PLAN COVERAGE PURSUANT TO SUBSECTION A OF THIS SECTION IF:

1. THE INDIVIDUAL HAS OR OBTAINS HEALTH INSURANCE COVERAGE OR WOULD BE ELIGIBLE FOR HEALTH INSURANCE COVERAGE IF THE INDIVIDUAL ELECTED TO OBTAIN IT, EXCEPT THAT AN INDIVIDUAL MAY MAINTAIN PLAN COVERAGE FOR THE PERIOD OF TIME THE INDIVIDUAL IS SATISFYING A PREEXISTING CONDITION WAITING PERIOD UNDER ANOTHER HEALTH INSURANCE POLICY.

2. THE INDIVIDUAL IS ELIGIBLE FOR HEALTH CARE BENEFITS UNDER TITLE 36, CHAPTER 29, MEDICARE OR ANY OTHER GOVERNMENT PROGRAM.

3. THE INDIVIDUAL VOLUNTARILY TERMINATED HEALTH INSURANCE COVERAGE UNLESS TWELVE MONTHS HAVE PASSED SINCE THE TERMINATION.

4. THE INDIVIDUAL IS AN INMATE OR RESIDENT OF A PUBLIC INSTITUTION.

5. THE INDIVIDUAL'S PLAN PREMIUMS ARE PAID FOR OR REIMBURSED UNDER ANY GOVERNMENT SPONSORED PROGRAM OR BY ANY GOVERNMENT AGENCY.

C. FROM AND AFTER JUNE 30, 2007, EXCEPT UNDER THE CIRCUMSTANCES DESCRIBED IN SUBSECTION B OF THIS SECTION, AN INDIVIDUAL WHO CEASES TO MEET THE ELIGIBILITY REQUIREMENTS OF THIS SECTION MAY BE TERMINATED AT THE END OF THE POLICY PERIOD FOR WHICH THE NECESSARY PREMIUMS HAVE BEEN PAID.

D. FROM AND AFTER JUNE 30, 2007, NOTWITHSTANDING SUBSECTION A OF THIS SECTION, AN INDIVIDUAL IS AN ELIGIBLE INDIVIDUAL IF:

1. THE INDIVIDUAL IS AN INDIVIDUAL ENROLLEE IN A HEALTH CARE SERVICES ORGANIZATION THAT IS DOMICILED IN THIS STATE ON THE DATE THAT THE HEALTH CARE SERVICES ORGANIZATION IS DECLARED INSOLVENT, INCLUDING ANY HEALTH CARE SERVICES ORGANIZATION THAT IS NOT AN ACCOUNTABLE HEALTH PLAN AS DEFINED IN SECTION 20-2301.

2. THE INDIVIDUAL'S COVERAGE TERMINATES DURING THE DELINQUENCY PROCEEDING, AFTER THE HEALTH CARE SERVICES ORGANIZATION IS DECLARED INSOLVENT.

3. THE INDIVIDUAL SATISFIES THE REQUIREMENTS OF AN ELIGIBLE INDIVIDUAL AS PRESCRIBED IN THIS SECTION OTHER THAN THE REQUIRED PERIOD OF CREDITABLE COVERAGE.

E. FROM AND AFTER JUNE 30, 2007, NOTWITHSTANDING SUBSECTION A OF THIS SECTION, A NEWBORN CHILD OF AN ELIGIBLE INDIVIDUAL, ADOPTED CHILD OF AN ELIGIBLE INDIVIDUAL OR CHILD PLACED FOR ADOPTION WITH AN ELIGIBLE INDIVIDUAL IS AN ELIGIBLE INDIVIDUAL IF THE CHILD WAS ENROLLED WITHIN THIRTY DAYS AND OTHERWISE WOULD HAVE MET THE DEFINITION OF AN ELIGIBLE INDIVIDUAL AS PRESCRIBED IN THIS SECTION OTHER THAN THE REQUIRED PERIOD OF CREDITABLE COVERAGE AND THE CHILD IS NOT SUBJECT TO ANY PREEXISTING CONDITION EXCLUSION OR LIMITATION IF THE CHILD HAS BEEN COVERED UNDER HEALTH INSURANCE COVERAGE OR A HEALTH BENEFITS PLAN OFFERED BY AN ACCOUNTABLE HEALTH PLAN SINCE BIRTH, ADOPTION OR PLACEMENT FOR ADOPTION WITH NO SIGNIFICANT BREAK IN COVERAGE.

20-3207. Eligibility standards for federally qualified individuals

A. FROM AND AFTER JUNE 30, 2007, AN INDIVIDUAL IS A FEDERALLY QUALIFIED INDIVIDUAL AND ELIGIBLE FOR PLAN COVERAGE IF ALL THE FOLLOWING APPLY:

1. THE INDIVIDUAL HAS NOT EXPERIENCED A SIGNIFICANT BREAK IN COVERAGE.

2. THE INDIVIDUAL CONTINUES TO BE A RESIDENT OF THIS STATE.

3. THE INDIVIDUAL HAS AN AGGREGATE PERIOD OF CREDITABLE COVERAGE AS DEFINED AND CALCULATED PURSUANT TO THIS ARTICLE OF AT LEAST EIGHTEEN MONTHS.

4. THE MOST RECENT CREDITABLE COVERAGE FOR THE INDIVIDUAL WAS UNDER A PLAN OFFERED BY:

(a) AN EMPLOYEE WELFARE BENEFIT PLAN THAT PROVIDES MEDICAL CARE TO EMPLOYEES OR THE EMPLOYEES' DEPENDENTS DIRECTLY OR THROUGH INSURANCE OR REIMBURSEMENT OR OTHERWISE PURSUANT TO ERISA.

(b) A CHURCH PLAN.

(c) A GOVERNMENT PLAN, INCLUDING A PLAN ESTABLISHED OR MAINTAINED FOR ITS EMPLOYEES BY THE GOVERNMENT OF THE UNITED STATES OR BY ANY AGENCY OR INSTRUMENTALITY OF THE UNITED STATES.

(d) AN ACCOUNTABLE HEALTH PLAN AS DEFINED IN SECTION 20-2301.

(e) A PLAN MADE AVAILABLE TO A PERSON DEFINED AS ELIGIBLE PURSUANT TO SECTION 36-2901, PARAGRAPH 6, SUBDIVISION (d) OR A DEPENDENT PURSUANT TO SECTION 36-2901, PARAGRAPH 6, SUBDIVISION (e) OF A PERSON ELIGIBLE UNDER SECTION 36-2901, PARAGRAPH 6, SUBDIVISION (d), IF THE PERSON WAS MOST RECENTLY EMPLOYED BY A BUSINESS IN THIS STATE WITH AT LEAST TWO BUT NOT MORE THAN FIFTY FULL-TIME EMPLOYEES.

5. THE INDIVIDUAL IS NOT ELIGIBLE FOR COVERAGE UNDER:

(a) AN EMPLOYEE WELFARE BENEFIT PLAN THAT PROVIDES MEDICAL CARE TO EMPLOYEES OR THE EMPLOYEES' DEPENDENTS DIRECTLY OR THROUGH INSURANCE OR REIMBURSEMENT OR OTHERWISE PURSUANT TO ERISA.

(b) A HEALTH BENEFITS PLAN ISSUED BY AN ACCOUNTABLE HEALTH PLAN AS DEFINED IN SECTION 20-2301.

(c) PART A OR PART B OF TITLE XVIII OF THE SOCIAL SECURITY ACT.

(d) TITLE 36, CHAPTER 29, EXCEPT COVERAGE TO PERSONS DEFINED AS ELIGIBLE UNDER SECTION 36-2901, PARAGRAPH 6, SUBDIVISIONS (b), (c), (d) AND (e), OR ANY OTHER PLAN ESTABLISHED UNDER TITLE XIX OF THE SOCIAL SECURITY ACT, AND THE INDIVIDUAL DOES NOT HAVE OTHER HEALTH INSURANCE COVERAGE.

6. THE MOST RECENT COVERAGE WITHIN THE COVERAGE PERIOD WAS NOT TERMINATED BASED ON ANY FACTOR DESCRIBED IN SECTION 20-2309, SUBSECTION B, PARAGRAPH 1 OR 2 RELATING TO THE INDIVIDUAL'S NONPAYMENT OF PREMIUMS OR FRAUD.

7. THE INDIVIDUAL WAS OFFERED, ELECTED THE OPTION OF AND EXHAUSTED CONTINUATION COVERAGE UNDER A COBRA CONTINUATION PROVISION PURSUANT TO THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (P.L. 99-272; 100 STAT. 82) OR A SIMILAR STATE PROGRAM.

B. FROM AND AFTER JUNE 30, 2007, NOTWITHSTANDING SUBSECTION A OF THIS SECTION, A NEWBORN CHILD OF AN ELIGIBLE INDIVIDUAL, ADOPTED CHILD OF AN ELIGIBLE INDIVIDUAL OR CHILD PLACED FOR ADOPTION WITH AN ELIGIBLE INDIVIDUAL IS AN ELIGIBLE INDIVIDUAL IF THE CHILD WAS ENROLLED WITHIN THIRTY DAYS AND OTHERWISE WOULD HAVE MET THE DEFINITION OF AN ELIGIBLE INDIVIDUAL AS PRESCRIBED IN THIS SECTION OTHER THAN THE REQUIRED PERIOD OF CREDITABLE COVERAGE AND THE CHILD IS NOT SUBJECT TO ANY PREEXISTING CONDITION EXCLUSION

OR LIMITATION IF THE CHILD HAS BEEN COVERED UNDER HEALTH INSURANCE COVERAGE OR A HEALTH BENEFITS PLAN OFFERED BY AN ACCOUNTABLE HEALTH PLAN SINCE BIRTH, ADOPTION OR PLACEMENT FOR ADOPTION WITH NO SIGNIFICANT BREAK IN COVERAGE.

20-3208. Dependent coverage

FROM AND AFTER JUNE 30, 2007, EACH DEPENDENT OF AN ELIGIBLE UNINSURABLE INDIVIDUAL OR A FEDERALLY QUALIFIED ELIGIBLE INDIVIDUAL IS ELIGIBLE FOR PLAN COVERAGE AT THE PLAN PREMIUMS ESTABLISHED IN SECTION 20-3211. THE PARENT SHALL FURNISH PROOF OF INCAPACITY AND DEPENDENCY TO THE PLAN WITHIN THIRTY-ONE DAYS OF THE CHILD ATTAINING NINETEEN YEARS OF AGE AND SUBSEQUENTLY AS THE PLAN REQUIRES, BUT NOT MORE FREQUENTLY THAN ANNUALLY.

20-3209. Cessation of coverage

PLAN COVERAGE CEASES:

1. ON THE DATE AN INDIVIDUAL IS NO LONGER A RESIDENT OF THIS STATE.

2. ON THE DATE AN INDIVIDUAL REQUESTS COVERAGE TO END.

3. ON THE DEATH OF THE COVERED INDIVIDUAL.

4. ON THE DATE STATE LAW REQUIRES CANCELLATION OF THE POLICY.

5. AT THE OPTION OF THE BOARD, THIRTY DAYS AFTER THE PLAN MAKES ANY INQUIRY CONCERNING THE INDIVIDUAL'S ELIGIBILITY OR PLACE OF RESIDENCE TO WHICH THE INDIVIDUAL DOES NOT REPLY.

6. ON THE DATE AN INDIVIDUAL'S COVERAGE HAS LAPSED DUE TO FAILURE TO PAY PREMIUMS, SUBJECT TO ANY GRACE PERIOD PROVIDED BY THE PLAN.

7. ON THE DATE THE PLAN HAS PAID OUT ONE MILLION DOLLARS IN BENEFITS ON BEHALF OF THE INDIVIDUAL. THE BOARD MAY INCREASE THIS AMOUNT FOR PLAN COVERAGE IF THE INCREASE APPLIES UNIFORMLY TO ALL INDIVIDUALS IN A SPECIFIC POLICY OFFERING UNDER THE PLAN AND WITHOUT REGARD TO HEALTH STATUS.

20-3210. Plan administrator

A. THE BOARD SHALL SELECT A PLAN ADMINISTRATOR THROUGH A COMPETITIVE BIDDING PROCESS PURSUANT TO TITLE 41, CHAPTER 23. THE BOARD SHALL EVALUATE BIDS SUBMITTED BASED ON CRITERIA ESTABLISHED BY THE BOARD THAT INCLUDE:

1. THE APPLICANT'S PROVEN ABILITY TO PROVIDE HEALTH INSURANCE COVERAGE TO INDIVIDUALS.

2. THE EFFICIENCY AND TIMELINESS OF THE APPLICANT'S CLAIM PROCESSING PROCEDURES.

3. AN ESTIMATE OF TOTAL CHARGES FOR ADMINISTERING THE PLAN.

4. THE APPLICANT'S ABILITY TO APPLY EFFECTIVE COST CONTAINMENT PROGRAMS AND PROCEDURES AND TO ADMINISTER THE PLAN IN A COST-EFFECTIVE MANNER.

5. THE APPLICANT'S FINANCIAL CONDITION AND STABILITY.

B. THE PLAN ADMINISTRATOR SHALL SERVE FOR THE PERIOD SPECIFIED IN THE CONTRACT BETWEEN THE BOARD AND THE PLAN ADMINISTRATOR. THE MINIMUM CONTRACT PERIOD SHALL BE THREE YEARS. EITHER PARTY MAY CANCEL THE CONTRACT DURING THE CONTRACT PERIOD BY PROVIDING ONE HUNDRED FIFTY DAYS' WRITTEN NOTICE TO THE OTHER PARTY. AT LEAST ONE YEAR BEFORE THE EXPIRATION OF EACH CONTRACT PERIOD, THE BOARD SHALL INVITE ELIGIBLE ENTITIES TO SUBMIT BIDS TO SERVE AS

THE PLAN ADMINISTRATOR. THE BOARD SHALL SELECT THE PLAN ADMINISTRATOR FOR THE SUCCEEDING PERIOD AT LEAST SIX MONTHS BEFORE THE END OF THE CURRENT PERIOD.

C. THE PLAN ADMINISTRATOR SHALL PERFORM THE FUNCTIONS ASSIGNED TO IT, INCLUDING:

1. DETERMINATION OF ELIGIBILITY.

2. PAYMENT OF CLAIMS.

3. ESTABLISHMENT OF A PREMIUM BILLING PROCEDURE FOR COLLECTION OF PREMIUMS.

4. OTHER NECESSARY FUNCTIONS TO ASSURE TIMELY PAYMENT OF BENEFITS TO COVERED PERSONS.

D. THE PLAN ADMINISTRATOR SHALL SUBMIT QUARTERLY REPORTS TO THE BOARD REGARDING THE OPERATION OF THE PLAN, INCLUDING NET WRITTEN AND EARNED PREMIUMS, THE EXPENSE OF ADMINISTRATION AND THE PAID AND INCURRED LOSSES FOR THE QUARTER.

E. THE PLAN ADMINISTRATOR SHALL BE PAID AS PROVIDED IN THE CONTRACT BETWEEN THE BOARD AND THE PLAN ADMINISTRATOR.

20-3211. Premium rates

THE PLAN SHALL ESTABLISH PREMIUM RATES AS FOLLOWS:

1. THE BOARD SHALL DETERMINE A STANDARD PREMIUM BY CONSIDERING THE PREMIUM RATES CHARGED BY INSURERS OFFERING INDIVIDUAL HEALTH INSURANCE COVERAGE. A MEMBER OF THE AMERICAN ACADEMY OF ACTUARIES SHALL CERTIFY THAT THE BOARD DEVELOPED THE STANDARD PREMIUM USING ACCEPTED ACTUARIAL TECHNIQUES AND THAT THE PREMIUM REFLECTS ANTICIPATED EXPERIENCE AND EXPENSES FOR THE COVERAGE. EXCEPT AS PROVIDED IN SECTION 20-3213, THE PLAN PREMIUM SHALL NOT EXCEED TWO HUNDRED PER CENT OF THE STANDARD PREMIUM. SUBJECT TO THE LIMITS PROVIDED IN THIS PARAGRAPH, RATES SHALL BE ESTABLISHED TO PROVIDE FULLY FOR THE EXPECTED COSTS OF CLAIMS, INCLUDING RECOVERY OF PRIOR LOSSES, EXPENSES OF OPERATION, INVESTMENT INCOME OF PLAN RESERVES AND ANY OTHER COST FACTORS. PREMIUMS ARE PAYABLE TO THE BOARD. THE BOARD SHALL DEPOSIT PREMIUMS IT RECEIVES IN THE STATE HEALTH INSURANCE PLAN FOR UNINSURABLE INDIVIDUALS FUND ESTABLISHED BY SECTION 20-3219.

2. PREMIUM RATES MAY VARY BASED ON AGE, GENDER AND GEOGRAPHICAL LOCATION AND MAY APPLY TO INDIVIDUAL RISKS.

20-3212. Balancing income and expenses

A. IF THE PLAN'S INCOME IN ANY FISCAL YEAR IS MORE THAN THE PLAN'S ACTUAL LOSSES AND ADMINISTRATIVE EXPENSES, THE BOARD SHALL HOLD THE EXCESS IN AN INTEREST-BEARING ACCOUNT AND USE THE EXCESS TO OFFSET FUTURE LOSSES. FOR THE PURPOSES OF THIS SUBSECTION, "FUTURE LOSSES" INCLUDES RESERVES FOR INCURRED BUT NOT REPORTED CLAIMS.

B. THE BOARD SHALL OPERATE THE PLAN IN A MANNER SO THAT THE ESTIMATED COST OF PROVIDING COVERAGE DURING ANY FISCAL YEAR WILL NOT EXCEED THE TOTAL INCOME THE PLAN EXPECTS TO RECEIVE FROM POLICY PREMIUMS DEPOSITS MADE PURSUANT TO SECTION 20-224. AFTER DETERMINING THE AMOUNT OF MONIES IT EXPECTS TO RECEIVE FROM POLICY PREMIUMS AND MONIES DEPOSITED TO THE FUND FOR A FISCAL YEAR, THE BOARD SHALL ESTIMATE THE NUMBER OF NEW POLICIES IT

BELIEVES THE PLAN HAS THE FINANCIAL CAPACITY TO INSURE DURING THAT YEAR SO THAT COSTS DO NOT EXCEED INCOME.

20-3213. Emergency enrollment limits

THE BOARD SHALL CAREFULLY CALCULATE AND ADJUST PREMIUMS TO ENSURE THE PLAN'S SOLVENCY. IF THE BOARD ANTICIPATES THE INCOME FROM PREMIUMS AND MONIES DEPOSITED TO THE FUND WILL BE INSUFFICIENT TO COVER THE PLAN'S EXPENSES, IT SHALL DECLARE AN EMERGENCY, LIMIT ENROLLMENT IN THE PLAN FOR UNINSURABLE INDIVIDUALS WHO ARE ELIGIBLE FOR PLAN COVERAGE PURSUANT TO SECTION 20-3206 AND INCREASE THE PREMIUM RATES PRESCRIBED BY SECTION 20-3211.

20-3214. Prior group coverage; certificate of creditable coverage; calculating creditable coverage

A. THE BOARD SHALL PROVIDE, WITHOUT CHARGE, A WRITTEN CERTIFICATE OF CREDITABLE COVERAGE AS DESCRIBED IN SECTION 20-1380 ON REQUEST OF AN INDIVIDUAL WHO IS TERMINATED FROM PLAN COVERAGE.

B. PERIODS OF CREDITABLE COVERAGE FOR AN INDIVIDUAL ARE ESTABLISHED BY THE PRESENTATION OF THE CERTIFICATE DESCRIBED IN THIS SECTION AND SECTION 20-2310. IN ADDITION TO THE WRITTEN CERTIFICATE OF CREDITABLE COVERAGE AS DESCRIBED IN SECTIONS 20-1380 AND 20-2310, INDIVIDUALS MAY ESTABLISH CREDITABLE COVERAGE THROUGH THE PRESENTATION OF DOCUMENTS OR OTHER MEANS. IN ORDER TO MAKE A DETERMINATION THAT IS BASED ON THE RELEVANT FACTS AND CIRCUMSTANCES OF THE AMOUNT OF CREDITABLE COVERAGE THAT AN INDIVIDUAL HAS, THE BOARD SHALL TAKE INTO ACCOUNT ALL INFORMATION THAT IT OBTAINS OR THAT IS PRESENTED ON BEHALF OF THE INDIVIDUAL.

C. THE BOARD SHALL CALCULATE CREDITABLE COVERAGE ACCORDING TO THE FOLLOWING RULES:

1. THE BOARD SHALL ALLOW AN INDIVIDUAL CREDIT FOR EACH DAY THE INDIVIDUAL WAS COVERED BY CREDITABLE COVERAGE.

2. THE BOARD SHALL NOT COUNT A PERIOD OF CREDITABLE COVERAGE FOR AN INDIVIDUAL ENROLLED UNDER ANY FORM OF HEALTH INSURANCE COVERAGE IF, AFTER THE PERIOD OF COVERAGE AND BEFORE THE ENROLLMENT DATE, THERE WERE SIXTY-THREE CONSECUTIVE DAYS DURING WHICH THE INDIVIDUAL WAS NOT COVERED BY ANY CREDITABLE COVERAGE.

3. THE BOARD SHALL NOT INCLUDE ANY PERIOD THAT AN INDIVIDUAL IS IN A WAITING PERIOD OR AN AFFILIATION PERIOD FOR COVERAGE OR IS AWAITING ACTION BY THE BOARD ON AN APPLICATION FOR PLAN COVERAGE WHEN BOARD DETERMINES THE CONTINUOUS PERIOD PURSUANT TO PARAGRAPH 1.

4. THE BOARD SHALL NOT COUNT A PERIOD OF CREDITABLE COVERAGE WITH RESPECT TO ENROLLMENT OF AN INDIVIDUAL IF, AFTER THE MOST RECENT PERIOD OF CREDITABLE COVERAGE AND BEFORE THE ENROLLMENT DATE IN THE PLAN, SIXTY-THREE CONSECUTIVE DAYS LAPSE DURING ALL OF WHICH THE INDIVIDUAL WAS NOT COVERED UNDER ANY CREDITABLE COVERAGE. THE BOARD SHALL NOT INCLUDE IN THE DETERMINATION OF THE PERIOD OF CONTINUOUS COVERAGE DESCRIBED IN THIS SECTION ANY PERIOD THAT AN INDIVIDUAL IS IN A WAITING PERIOD FOR HEALTH INSURANCE COVERAGE, IS IN A WAITING PERIOD FOR BENEFITS UNDER A HEALTH BENEFITS PLAN OFFERED BY AN ACCOUNTABLE HEALTH PLAN OR IS IN AN AFFILIATION PERIOD.

5. IN DETERMINING THE EXTENT TO WHICH AN INDIVIDUAL HAS SATISFIED ANY PORTION OF ANY APPLICABLE PREEXISTING CONDITION PERIOD, THE BOARD SHALL COUNT A PERIOD OF CREDITABLE COVERAGE WITHOUT REGARD TO THE SPECIFIC BENEFITS COVERED DURING THAT PERIOD.

20-3215. Benefits

A. FROM AND AFTER JUNE 30, 2007, THE PLAN SHALL OFFER ELIGIBLE INDIVIDUALS COMPREHENSIVE HEALTH CARE COVERAGE CONSISTENT WITH INDIVIDUAL HEALTH INSURANCE COVERAGE OFFERED IN THIS STATE TO ELIGIBLE INDIVIDUALS. THE BOARD SHALL ESTABLISH THE COVERAGE TO BE ISSUED BY THE PLAN AND ITS SCHEDULE OF BENEFITS, EXCLUSIONS AND OTHER LIMITATIONS. THE BOARD SHALL PROVIDE A CHOICE OF COVERAGE CONSISTENT WITH FEDERAL LAW.

B. THE BOARD SHALL NOT PROVIDE COVERAGE FOR BENEFITS OBTAINED OUTSIDE OF THIS STATE OTHER THAN FOR EMERGENCY TREATMENT AS DESCRIBED IN THE PLAN OF OPERATION.

C. THE BOARD MAY ADJUST ANY BENEFITS DEDUCTIBLES AND COINSURANCE FACTORS ANNUALLY.

D. NOTWITHSTANDING ANY OTHER LAW, THE PLAN IS NOT SUBJECT TO ANY STATE HEALTH INSURANCE BENEFIT MANDATES BUT IS SUBJECT TO ALL FEDERAL INSURANCE MANDATES.

E. THE PLAN SHALL BE A PAYOR OF LAST RESORT OF BENEFITS IF ANY OTHER BENEFIT OR SOURCE OF THIRD-PARTY PAYMENT IS AVAILABLE. BENEFITS OTHERWISE PAYABLE UNDER PLAN COVERAGE SHALL BE REDUCED BY ALL AMOUNTS PAID OR PAYABLE THROUGH ANY OTHER HEALTH INSURANCE AND BY ALL HOSPITAL AND MEDICAL EXPENSE BENEFITS PAID OR PAYABLE UNDER ANY WORKERS' COMPENSATION COVERAGE, AUTOMOBILE MEDICAL PAYMENTS COVERAGE OR LIABILITY INSURANCE WHETHER PROVIDED ON THE BASIS OF FAULT OR NONFAULT AND BY ANY HOSPITAL OR MEDICAL BENEFITS PAID OR PAYABLE UNDER OR PROVIDED PURSUANT TO ANY STATE OR FEDERAL LAW OR PROGRAM. THE BOARD HAS A CAUSE OF ACTION AGAINST AN ELIGIBLE INDIVIDUAL FOR THE RECOVERY OF THE AMOUNT OF BENEFITS PAID THAT ARE NOT COVERED BENEFITS AND AGAINST AN INELIGIBLE INDIVIDUAL FOR THE RECOVERY OF THE AMOUNT OF BENEFITS PAID. BENEFITS DUE FROM THE PLAN MAY BE REDUCED OR REFUSED AS A SETOFF AGAINST ANY AMOUNT RECOVERABLE UNDER THIS SUBSECTION.

F. A PREEXISTING CONDITION LIMITATION APPLIES TO AN UNINSURABLE INDIVIDUAL'S PLAN COVERAGE DURING THE FIRST TWELVE MONTHS AFTER THE EFFECTIVE DATE OF PLAN COVERAGE. A PREEXISTING CONDITION EXCLUSION DOES NOT APPLY TO A FEDERALLY QUALIFIED INDIVIDUAL AS DESCRIBED IN SECTION 20-3207.

G. THE PREEXISTING CONDITION EXCLUSION ESTABLISHED IN SUBSECTION F OF THIS SECTION IS WAIVED TO THE EXTENT THAT SIMILAR EXCLUSIONS, IF ANY, HAVE BEEN SATISFIED UNDER ANY PRIOR HEALTH INSURANCE COVERAGE THAT WAS INVOLUNTARILY TERMINATED AND IF:

1. THE APPLICATION FOR PLAN COVERAGE IS MADE NOT LATER THAN SIXTY DAYS AFTER THE INVOLUNTARY TERMINATION AND COVERAGE IN THE PLAN IS EFFECTIVE FROM THE DATE ON WHICH THE PRIOR COVERAGE WAS TERMINATED.

2. THE APPLICANT IS NOT ELIGIBLE FOR CONTINUATION OR CONVERSION RIGHTS THAT WOULD PROVIDE COVERAGE SUBSTANTIALLY SIMILAR TO THE PLAN COVERAGE.

20-3216. Collective action

NEITHER THE PARTICIPATION IN THE PLAN AS PLAN ADMINISTRATOR, THE ESTABLISHMENT OF RATES, FORMS OR PROCEDURES NOR ANY OTHER JOINT OR COLLECTIVE ACTION REQUIRED BY THIS CHAPTER MAY BE THE BASIS OF ANY LEGAL ACTION, CRIMINAL OR CIVIL LIABILITY OR PENALTY AGAINST THE PLAN OR ANY PARTICIPATING INSURER.

20-3217. Exemption from taxation

THE PLAN IS EXEMPT FROM ALL TAXES.

20-3218. Lien on damages recovered by injured person; perfection, recording, assignment and notice of lien; release; enforcement

A. THE BOARD IS ENTITLED TO A LIEN FOR THE BENEFITS PROVIDED TO AN INDIVIDUAL FOR WHICH THE PLAN IS RESPONSIBLE ON ANY AND ALL CLAIMS OF LIABILITY OR INDEMNITY FOR DAMAGES ACCRUING TO THE INDIVIDUAL TO WHOM BENEFITS WERE PROVIDED, OR TO THE LEGAL REPRESENTATIVE OF THE INDIVIDUAL, ON ACCOUNT OF INJURIES THAT GAVE RISE TO THE CLAIMS AND THAT NECESSITATED THE PAYMENT OF BENEFITS.

B. TO PERFECT A LIEN PURSUANT TO THIS SECTION, THE BOARD'S AUTHORIZED REPRESENTATIVE, BEFORE OR WITHIN SIXTY DAYS AFTER THE DATE OF FINAL PAYMENT OF BENEFITS, SHALL RECORD IN THE OFFICE OF THE RECORDER OF THE COUNTY IN WHICH THE INJURIES WERE INCURRED A VERIFIED STATEMENT IN WRITING SETTING FORTH THE NAME AND ADDRESS OF THE INDIVIDUAL AS THEY APPEAR ON THE PLAN'S RECORDS, THE PLAN'S NAME AND ADDRESS, THE DATES OF THE INDIVIDUAL'S ADMISSION TO AND DISCHARGE FROM THE HOSPITAL OR THE DATES ON WHICH MEDICAL CARE AND TREATMENT WERE PROVIDED TO THE INDIVIDUAL, THE DATES AND AMOUNTS OF BENEFITS PAID BY THE PLAN AND, TO THE BEST OF THE BOARD'S KNOWLEDGE, THE NAMES AND ADDRESSES OF ALL INDIVIDUALS, FIRMS OR CORPORATIONS AND THEIR INSURANCE CARRIERS ALLEGED BY THE INJURED INDIVIDUAL OR THE INDIVIDUAL'S LEGAL REPRESENTATIVE TO BE LIABLE FOR DAMAGES ARISING FROM THE INJURIES FOR WHICH THE INDIVIDUAL RECEIVED BENEFITS FROM THE PLAN. THE BOARD OR ITS AUTHORIZED REPRESENTATIVE IS NOT REQUIRED TO INCLUDE THE ADDRESS OF THE INDIVIDUAL IN THE VERIFIED STATEMENT IF THE PLAN'S RECORDS INDICATE THAT THE INDIVIDUAL'S INJURIES MAY HAVE RESULTED FROM AN OFFENSE, AS DEFINED IN SECTION 13-105, AGAINST THE INDIVIDUAL. WITHIN FIVE DAYS AFTER RECORDING THE LIEN, THE BOARD'S AUTHORIZED REPRESENTATIVE SHALL ALSO MAIL A COPY OF THE LIEN, POSTAGE PREPAID, TO THE INDIVIDUAL AND TO EACH PERSON, FIRM OR CORPORATION, INCLUDING INSURANCE CARRIERS, THAT IS ALLEGED TO BE LIABLE FOR LIABILITY OR INDEMNITY DAMAGES, AT THE ADDRESS GIVEN IN THE STATEMENT. THE RECORDING OF THE LIEN IS NOTICE OF THE LIEN TO ALL PERSONS, FIRMS OR CORPORATIONS, INCLUDING INSURANCE CARRIERS, THAT ARE LIABLE FOR LIABILITY OR INDEMNITY DAMAGES, WHETHER OR NOT THEY ARE NAMED IN THE LIEN.

C. THE RECORDER SHALL ENDORSE ON A LIEN RECORDED PURSUANT TO THIS SECTION THE DATE AND HOUR OF RECEIPT AND THOSE FACTS THAT ARE NECESSARY TO INDICATE THAT IT HAS BEEN RECORDED.

D. NOTWITHSTANDING ANY OTHER LAW, A LIEN PROVIDED FOR BY THIS CHAPTER HAS PRIORITY OVER ALL OTHER LIENS.

E. A LIEN AUTHORIZED PURSUANT TO THIS CHAPTER MAY BE AMENDED TO REFLECT CURRENT CHARGES. IF THE BOARD IS GIVEN NOTICE OF AN IMPENDING SETTLEMENT OF THE INDIVIDUAL'S CLAIM AT LEAST FIFTEEN WORKING DAYS BEFORE THE FINAL SETTLEMENT OF THAT CLAIM, THE LIEN SHALL NOT BE AMENDED AFTER THE TIME OF FINAL SETTLEMENT.

F. THE BOARD SHALL COMPROMISE A CLAIM IT HAS PURSUANT TO THIS SECTION IF, AFTER CONSIDERING THE FACTORS LISTED IN SUBSECTION G OF THIS SECTION, THE COMPROMISE PROVIDES A SETTLEMENT OF THE CLAIM THAT IS FAIR AND EQUITABLE.

G. IN DETERMINING THE EXTENT OF THE COMPROMISE OF THE CLAIM REQUIRED BY SUBSECTION F OF THIS SECTION, THE BOARD SHALL CONSIDER THE FOLLOWING FACTORS:

1. THE NATURE AND EXTENT OF THE INDIVIDUAL'S INJURY OR ILLNESS.

2. THE SUFFICIENCY OF INSURANCE OR OTHER SOURCES OF INDEMNITY AVAILABLE TO THE INDIVIDUAL.

3. ANY OTHER FACTOR RELEVANT FOR A FAIR AND EQUITABLE SETTLEMENT UNDER THE CIRCUMSTANCES OF A PARTICULAR CASE.

H. A RELEASE OF A CLAIM ON WHICH A LIEN IS IMPOSED PURSUANT TO THIS SECTION IS NOT VALID OR EFFECTIVE AS AGAINST THE LIEN UNLESS THE BOARD JOINS IN THE RELEASE OR EXECUTES A RELEASE OF THE LIEN.

I. IF ANY AMOUNT HAS BEEN OR IS TO BE COLLECTED BY THE INJURED INDIVIDUAL OR THE INDIVIDUAL'S LEGAL REPRESENTATIVE FROM OR ON ACCOUNT OF THE PERSON, FIRM OR CORPORATION, INCLUDING INSURANCE CARRIERS, LIABLE FOR LIABILITY OR INDEMNITY DAMAGES BY REASON OF A JUDGMENT, SETTLEMENT OR COMPROMISE, THE BOARD MAY ENFORCE THE LIEN BY AN ACTION AGAINST THE INDIVIDUAL OR THE PERSON, FIRM OR CORPORATION, INCLUDING INSURANCE CARRIERS, LIABLE FOR LIABILITY OR INDEMNITY DAMAGES. THE ACTION SHALL BE COMMENCED AND TRIED IN THE COUNTY IN WHICH THE LIEN IS FILED, UNLESS THE COURT ORDERS THAT THE ACTION BE REMOVED TO ANOTHER COUNTY FOR CAUSE. IF THE BOARD PREVAILS IN THE ACTION, THE COURT MAY ALLOW THE BOARD ITS REASONABLE ATTORNEY FEES AND DISBURSEMENTS. AN ACTION SHALL BE COMMENCED WITHIN TWO YEARS AFTER THE ENTRY OF THE JUDGMENT OR THE MAKING OF THE SETTLEMENT OF COMPROMISE.

J. WITHIN THIRTY DAYS AFTER A LIEN PURSUANT TO THIS SECTION IS SATISFIED, THE BOARD SHALL ISSUE A RELEASE OF THE LIEN TO THE PERSON, FIRM OR CORPORATION AGAINST WHICH THE LIEN WAS CLAIMED. THE RELEASE SHALL CONFORM TO THE REQUIREMENTS OF SECTION 11-480.

20-3219. State health insurance plan for uninsurable individuals fund; sources and use of monies; investments

A. THE STATE HEALTH INSURANCE PLAN FOR UNINSURABLE INDIVIDUALS FUND IS ESTABLISHED. THE BOARD SHALL ADMINISTER THE FUND.

B. THE FUND CONSISTS OF MONIES RECEIVED FROM POLICY PREMIUMS AND AMOUNTS DEPOSITED PURSUANT TO SECTION 20-224.

C. THE BOARD MAY ACCEPT ANY GIFTS, GRANTS, DONATIONS OR APPROPRIATION OF MONIES FROM ANY PRIVATE OR PUBLIC SOURCE.

D. THE BOARD SHALL WITHDRAW AND DEPOSIT MONIES IN THE FUND AS NECESSARY TO OPERATE THE PLAN, INVEST PROCEEDS, ESTABLISH RESERVES AND PAY CLAIMS, SALARIES AND OTHER EXPENSES OF THE PLAN.

E. THE BOARD MAY INVEST MONIES AS IF IT WERE A HEALTH INSURER SUBJECT TO THIS TITLE. ON NOTICE FROM THE BOARD, THE STATE TREASURER SHALL INVEST AND DIVEST MONIES IN THE FUND AS PROVIDED BY SECTION 35-313, AND MONIES EARNED FROM INVESTMENT SHALL BE CREDITED TO THE FUND.

20-3220. Program termination

THE PROGRAM ESTABLISHED BY THIS CHAPTER ENDS ON JANUARY 1, 2017 PURSUANT TO SECTION 41-3102.

Sec. 20. Section 36-2982, Arizona Revised Statutes, is amended to read:

36-2982. Children's health insurance program; administration; nonentitlement; enrollment limitation; eligibility

A. The children's health insurance program is established for children who are eligible pursuant to section 36-2981, paragraph 6. The administration shall administer the program. All covered services shall be provided by health plans that have contracts with the administration pursuant to section 36-2906, by a qualifying plan or by either tribal facilities or the Indian health service for Native Americans who are eligible for the program and who elect to receive services through the Indian health service or a tribal facility.

B. This article does not create a legal entitlement for any applicant or member who is eligible for the program. Total enrollment is limited based on the annual appropriations made by the legislature and the enrollment cap prescribed in section 36-2985.

C. The director shall take all steps necessary to implement the administrative structure for the program and to begin delivering services to persons within sixty days after approval of the state plan by the United States department of health and human services.

D. The administration shall perform eligibility determinations for persons applying for eligibility and annual redeterminations for continued eligibility pursuant to this article.

E. The administration shall adopt rules for the collection of copayments from members whose income does not exceed one hundred fifty per cent of the federal poverty level and for the collection of copayments and premiums from members whose income exceeds one hundred fifty per cent of the federal poverty level. The director shall adopt rules for disenrolling a member if the member does not pay the premium required pursuant to this section. The director shall adopt rules to prescribe the circumstances under which the administration shall grant a hardship exemption to the disenrollment requirements of this subsection for a member who is no longer able to pay the premium.

F. Before enrollment, a member, or if the member is a minor, that member's parent or legal guardian, shall select an available health plan in the member's geographic service area or a qualifying health plan offered in the county, and may select a primary care physician or primary care practitioner from among the available physicians and practitioners participating with the contractor in which the member is enrolled. The contractors shall only reimburse costs of services or related services provided by or under referral from a primary care physician or primary care practitioner participating in the contract in which the member is enrolled, except for emergency services that shall be reimbursed pursuant to section 36-2987. The director shall establish requirements as to the minimum time period that a member is assigned to specific contractors.

G. Eligibility for the program is creditable coverage as defined in section ~~20-1379~~ 20-3201.

H. On application for eligibility for the program, the member, or if the member is a minor, the member's parent or guardian, shall receive an application for and a program description of the premium sharing program.

I. Notwithstanding section 36-2983, the administration may purchase for a member employer sponsored group health insurance with state and federal monies available pursuant to this article, subject to any restrictions imposed by the federal ~~health care financing administration~~ CENTERS FOR MEDICARE AND MEDICAID SERVICES. This subsection does not apply to members who are eligible for health benefits coverage under a state health benefits plan based on a family member's employment with a public agency in this state.

Sec. 21. Eligibility of individuals who currently have portability coverage

Notwithstanding section 20-3205, Arizona Revised Statutes, as added by this act, an individual and the individual's dependents who have coverage as of July 1, 2007 pursuant to section 20-1379, Arizona Revised Statutes, are eligible for coverage under the state health insurance plan for uninsurable individuals that is established by this act.

Sec. 22. Audit report

On or before September 15, 2011, the auditor general shall complete an audit of the state health insurance plan for uninsurable individuals established by this act and shall submit a report of its findings and recommendations to the governor, the president of the senate and the speaker of the house of representatives.

Sec. 23. Temporary use of department of insurance employees

The board of directors of the state health insurance plan for uninsurable individuals may use the services of the staff of the department of insurance to assist with setting meetings, hiring staff and other administrative tasks involved in establishing the plan. The board of directors shall compensate the department of insurance for the use of the employees.

Sec. 24. Initial terms of members of the board of directors of the state health insurance plan for uninsurable individuals

A. Notwithstanding section 20-3202, Arizona Revised Statutes, as added by this act, the initial terms of the voting members of the board of directors of the state health insurance plan for uninsurable individuals are:

1. One term ending January, 2009.
2. Two terms ending January, 2010.
3. Two terms ending January, 2011.
4. Two terms ending January, 2012.

B. The governor shall make all subsequent appointments as prescribed by statute.

Sec. 25. Delayed effective date

The following sections, as amended by this act, are effective from and after June 30, 2007:

1. 20-826.02, Arizona Revised Statutes.
2. 20-843, Arizona Revised Statutes.
3. 20-1057, Arizona Revised Statutes.
4. 20-1057.09, Arizona Revised Statutes.
5. 20-1068, Arizona Revised Statutes.
6. 20-1073, Arizona Revised Statutes.
7. 20-1342.04, Arizona Revised Statutes.
8. 20-1377, Arizona Revised Statutes.
9. 20-1378, Arizona Revised Statutes.
10. 20-1380, Arizona Revised Statutes.
11. 20-1408, Arizona Revised Statutes.
12. 20-1412, Arizona Revised Statutes.
13. 20-2308, Arizona Revised Statutes.
14. 20-2310, Arizona Revised Statutes.
15. 20-2331, Arizona Revised Statutes.
16. 36-2982, Arizona Revised Statutes.

Sec. 26. Appropriation; purpose; exemption

A. The sum of $154,200 is appropriated from the state general fund in fiscal year 2006-2007 to the department of insurance for personnel and administrative costs involved in establishing the state health insurance plan for uninsurable individuals.

B. The appropriation made in subsection A of this section is exempt from the provisions of section 35-190, Arizona Revised Statutes, relating to lapsing of appropriations.